HEALTH & SEGREGATION II

The Impact of the Israeli Separation Wall on Access to Health Care Services

An updated research, August 2005

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Contents

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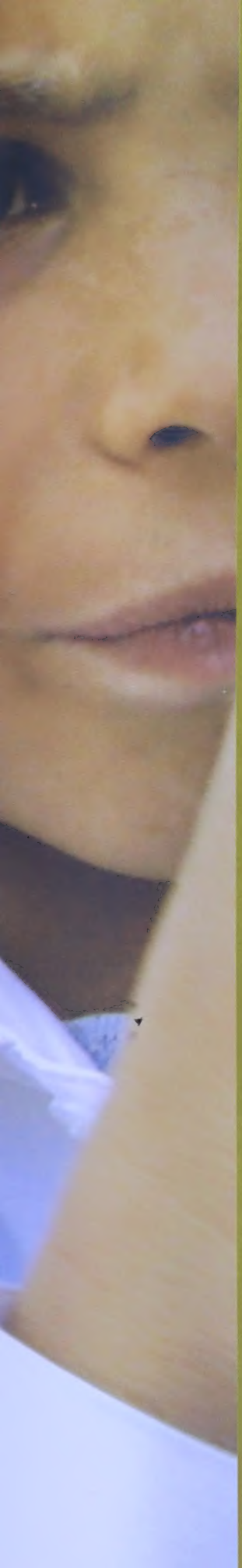
HDIP
Research Team



Background

Since the beginning of the construction of the Wall in 2002, the Palestinian Health, Development, Information and Policy Institute (HDIP) immediately became concerned with its impact on the health care system in the West Bank and the lack of comprehensive data about the health system's capacity to continue serving affected areas. With the aim of rapidly disseminating relevant existing information among local and international stakeholders, HDIP published Health and Segregation: The Impact of the Israeli Separation Wall on Access to Health Care Services in early 2004.

Health and Segregation I provides general and district-level assessments of the capacities and needs of health care providers and communities along the structure's first 157 km phase, stretching through the districts of Jenin, Tulkarem, Qalqiliya, parts of Jerusalem and Bethlehem. It also included (1) a survey of community perceptions of health needs intended to foster local community participation in health care planning, and help bridge the client-provider gap; and (2) preliminary assessments of its anticipated impact in remaining West Bank districts.

The resulting findings highlighted the serious challenges to Palestinian health care provision that the Wall poses. The picture offered was preliminary, however, and it was hoped that Health and Segregation I may help to motivate and to inform further studies on the subject, using more detailed indicators and covering a wider range of health issues. In cooperation with Medico International, it was deemed important to produce an updated report to analyse how access to health care services around the Wall have developed since 2004, what strategies health care providers have implemented to overcome access problems, and what challenges remain for the Palestinian health care system.

In order to produce this report, an innovative approach was adopted. This report is based not only on information collection about isolated and affected primary health care centres, hospitals and communities, but also on policy dialogue meetings and focus groups involving all health care providers in the formulation of recommendations and strategies regarding improving access to health care services. It must be stressed that the recommendations of this report came from these aforementioned meetings.

The report is divided into five main sections. **Section One** describes the context of the Wall and access problems faced by medical teams and patients throughout the year 2004-2005. **Section Two** is a general vulnerability assessment concerned with the primary health services affected by the Second Phase, as the capacity of health facilities along the First Phase were comprehensively covered in Health and Segregation I. Using previous analysis, along with new indicators, this section maps the communities isolated by the Wall, highlighting areas with weak health infrastructure, programmes and services. Furthermore, several health care providers confirmed that the Wall has negatively influenced access to tertiary care in Jerusalem as well as rehabilitation services. **Section Three** addresses these issues. **Section Four** provides an overview of the newly adopted strategies implemented by health care providers, with a special focus on mobile clinic activities in the isolated areas. Finally, **Section Five** adopts a more general approach to analysing national policies needed to develop the Palestinian health sector based on discussions, focus groups and meetings with the Ministry of Health, NGOs and UNRWA.

Objectives

According to the World Health Organization (WHO), systems for routine information that incorporate the needs of communities are the first to collapse in situations of social and political turbulences. Often, in such contexts, crucial decisions need to be made in the absence of health research, planning and the participation of underprivileged groups: a major dilemma confronting local and international humanitarian and development actors.[1] The fundamental decision relates to which priority health information is needed and how to monitor trends and support shifts in resource allocation for the health sector in emergency situations whilst continuously representing the real needs of vulnerable communities. The utmost challenge becomes "creating a culture of information sharing that promotes the systematic collection, use and free flow of data, information and ideas, facilitating informed decision-making and building trust and commitment among stakeholders" [2].

Within this context, rather than just presenting general information about the impact of the Wall on access to health care services, this report seeks to act as a policy paper by highlighting the main problems encountered by health care providers in isolated areas. This will enhance accessibility of information for interested groups, who can then plan efficiently for the Palestinian health care system.

[1] Health intelligence in emergencies: which information and why?, Health in Emergencies, WHO, Issue No. 15, December 2002, p.1.
[2] OCHA Symposium on Best Practices in Humanitarian Information Exchange.

Methodology

This research combines both quantitative and qualitative methods, as well as making use of available documentation and research literature.

1. Quantitative method sample design

The different measures imposed on Palestinian communities, including the Wall, Israeli checkpoints, road blocks, gates and settlers bypass roads, will result in the creation of 28 clusters (enclaves), encompassing 16 Palestinian communities with a total population of 385,508 which includes 41 primary health care clinics.[3] This report seeks to map vulnerable areas created by these measures in the realm of health care service provision.

Clusters were categorized according to three main typologies: Behind the Wall (in between the Wall and the Green Line), Complete Enclosure by the Wall (surrounded by the Wall from all sides) and Complete Enclosure by the Wall and Other Structures (surrounded by the Wall and settlement bypass roads forbidden to Palestinians). This classification is not just an indicator of the system of barriers impact on access to health care services, because the population within these different clusters will all experience access problems and will be isolated from other rural and urban communities in the West Bank. However, it is important to pioneer this typology as a means to understand the complicated policies imposed on Palestinian communities leading to their isolation.

Within this framework, the sample of the study included all primary health care facilities, which are or will be isolated by the Wall's First and Second Phases along these clusters. The total number of clinic questionnaires distributed was 41 with a response rate of 100%. The majority of the targeted facilities (19) were Ministry of Health clinics, 15 clinics were affiliated to different local health NGOs, 1 clinic was privately owned and 2 clinics were managed by UNRWA. Other types of questionnaires were disseminated to the three main health care providers (Ministry of Health, UNRWA and NGOs including PRCS, PMRS, HCC, HWC and PFS) who were carrying out mobile clinic programmes in areas of the Wall.

2. Quantitative research instruments

Quantitative research instruments used in this research were gathered mainly from two sources: existing databases and newly designed questionnaires.

2.1. Existing databases

HDIP already houses a comprehensive database of infrastructure and health services for Palestinian communities in the West Bank and Gaza. It was established in 1993 and has been updated biannually since, most recently in 2002-2003.

The Community Database holds community-level data on about 527 communities and villages. This includes demographic data, comprising community level information related to population size based on the 1997 population census conducted by the Palestinian Central Bureau of Statistics (PCBS), number of households and refugee population.

The Health Clinics Database stores detailed information about 507 primary health care facilities classified by operating organization and community. It offers figures about the infrastructure in and around the clinic, as well as staffing information. It shows the type and scope of services and programmes offered by each health care provider, consultation rates and fees.

Created in 2002, the Hospital Database contains general information about 54 hospitals in Palestine, the percentage of admissions to hospitals as compared to the year 2000, cases of patients prevented from travelling abroad and procedures implemented by organizations to cope with these conditions.

HDIP has also maintained a Barrier Database since 2002 that includes information about Israeli manned checkpoints, road blocks, gates and earth mounds in the West Bank and Gaza. Information was obtained from the Office for the Coordination of Humanitarian Affairs (OCHA) as well as from HDIP's field work.

Wall path information was retrieved from cartographic and GIS maps published by the Israeli government (Israeli Ministry of Defence). The route has changed three times and the latest one used in this report was published on the 20th February 2005. Other information was retrieved from local councils in isolated areas and verified by HDIP's field work.

2.2. New quantitative instruments

First focus group discussions were carried out with mobile clinic teams of Palestinian Medical Relief Society (PMRS) and the Palestinian Red Crescent Society (PRCS).

[3] One of the 28 enclaves includes East Jerusalem (enclave 19) with around 220,000 Palestinians and 6 primary health care centres and major hospitals serving Palestinians from the West Bank and Gaza

From discussions pertaining to the context within which mobile clinics operate and obstacles encountered by medical teams in the isolated areas, a set of health issues were selected for inclusion in the study. Moreover, several health care providers stated that the Wall had negatively affected access and level of rehabilitation services, and that the question of disability and problems faced by disabled individuals should be addressed at a national level. As a result, HDIP conducted further interviews with Dr. Allam Jarrar, Director of CBR-PMRS programme and Ziad Amro, Chairman of the Palestinian Union for the Disabled. Based on this, four new quantitative research instruments were designed:

- **Isolated clinics questionnaire and database** targeted health centres in Jenin, Tulkarem, Qalqiliya, Salfit, Ramallah, Jerusalem, Bethlehem and Hebron areas isolated by the First and Second Phases. It documents access problems encountered by medical staff working in the clinic as well as the difficulties faced by the clinic in procuring medications, vaccinations, and in conducting its services and programmes. Other questions aim at identifying practical steps and mechanisms currently implemented by clinics to provide health services to areas isolated and affected by the Wall, such as the change in staff working hours, their place of residence and clinic opening hours. Questionnaires were distributed to all primary health care centres in the isolated areas with a 100% response rate.

- **Mobile clinics questionnaire and database** identifies all mobile clinics working in isolated and affected areas in the districts of Jenin, Tulkarem, Qalqiliya, Salfit, Ramallah, Jerusalem, Bethlehem and Hebron. The aim is to document the number of mobile clinics by operating organization, start date, type of services provided, working programme and number of medical staff. Questionnaires were distributed to all health care providers working in the isolated areas with a 100% response rate.

- **Incident reports database** documents any denial of access and the delay of medical teams and patients in the West Bank and affected areas. A report was distributed to all health care providers so that incidents could be monitored. This information was then complemented by other reports from UNRWA, NGOs and OCHA and the Ministry of Health. The total number of incident reports collected numbered 375, over a period of 18 months.

- **Disability and rehabilitation focus group questions** were designed to assess the difficulties disabled people face in accessing rehabilitation services and how this has changed after the construction of the Wall in Jenin, Tulkarem, Qalqilya, Salfit, Ramallah, Jerusalem, Bethlehem and Hebron.

The data collection process officially started at the beginning of October 2004 and lasted until April 2005. Data collection was effected through field visits, focus group discussions and personal interviews. Analysis was completed using SPSS, Access and EpiInfo. Moreover, maps illustrating the isolation, distribution of health services and analysis of vulnerable communities were produced using HDIP's Geographic Information System (GIS) programme.

It should be noted here that data for mobile clinics and incident reports was collected not only for areas affected by the Wall but for the West Bank as a whole. However, information about all mobile clinics operating in the West Bank was not complete. Hence, we selected those operating in 1 km radius around the Wall area in order to efficiently analyse these models.

3. Qualitative aspects

The qualitative aspects of this report aimed not only to understand and validate the data collected, but also as a tool for policy formulation in cooperation with all health care providers. Quantitative information was collated from interviews, participatory focus discussions, meetings and workshops conducted with health care providers and community representatives in the areas of Jenin, Tulkarem, Qalqiliya, Salfit, Ramallah, Jerusalem, Bethlehem and Hebron.

Moreover, when the initial results of this study were prepared, HDIP organized a coordination meeting with UNRWA and health NGOs in cooperation with the Ministry of Health to discuss possible recommendations and national strategies to be adopted. The meeting was held in Ramallah on 19 May 2005 and was attended by 18 participants from the Jenin, Qalqiliya, Nablus, Ramallah, Bethlehem and Hebron directorates of the Ministry of Health as well as representatives from UNRWA, HCC, PRCS and PMRS. On 21 June 2005, HDIP also discussed the initial results of this research before its publication to the Health Sector Working Group that includes the Ministry of Health, Ministry of Planning and donors working in the health sector. On 23 June 2005, HDIP, in cooperation with the Ministry of Health and the Health Inforum organized the first mobile clinic coordination meeting with the main health care providers.

Research limitations

During the implementation of the study, the research team encountered four major obstacles. The first challenge was the repeated alteration of the Wall's path by the Israeli government; the most recent route was published on 20 February 2005. This implied constantly verifying data collected, organizing field visits, updating maps, re-collecting missing information and re-analysing health capacities of clinics. This process caused delays and the constant updating of information was very time consuming.

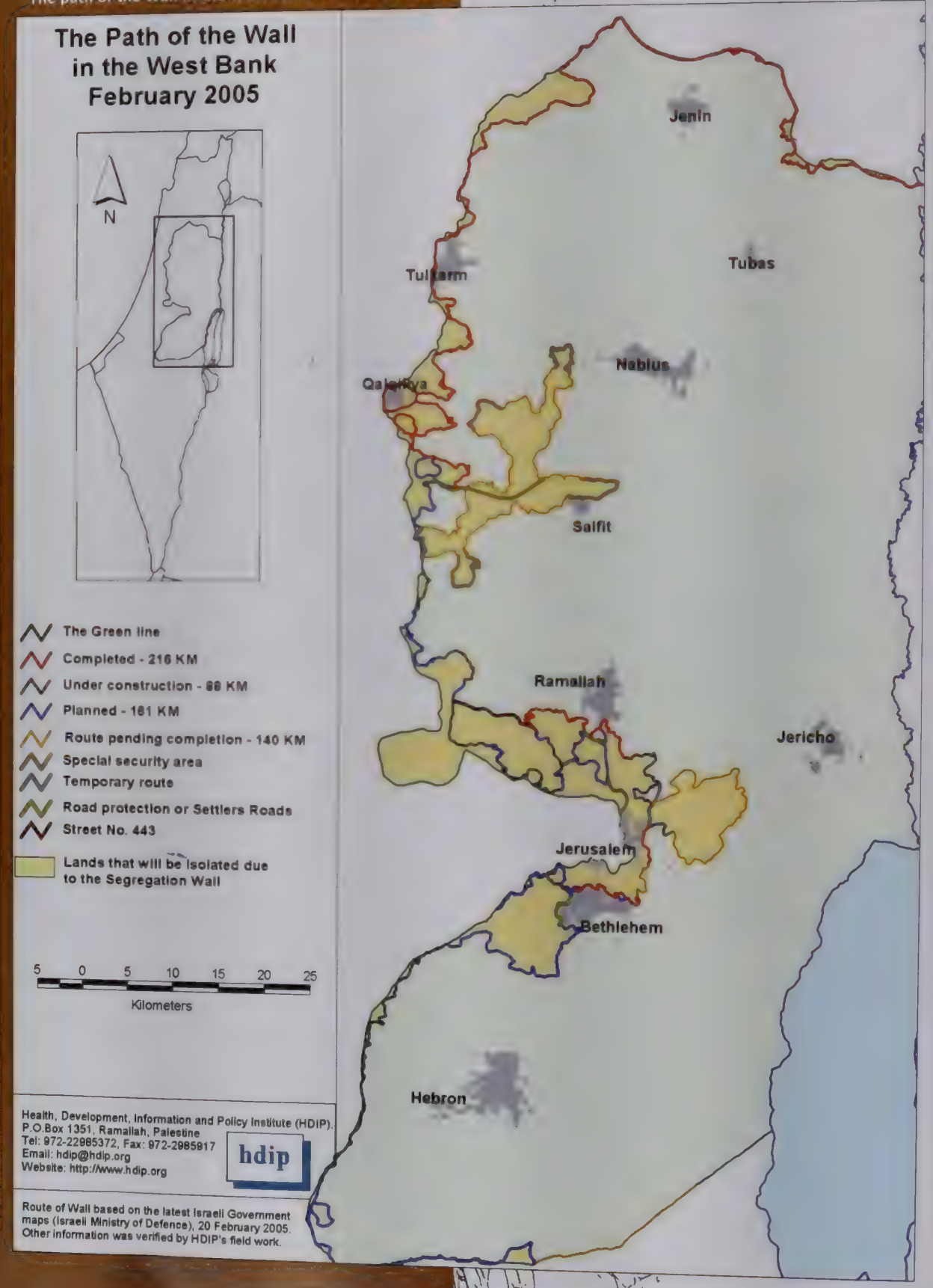
Secondly, access to affected health care facilities located in isolated areas was difficult. In areas that were difficult to access, questionnaires were filled in by the doctor or nurse available at the clinic, and were collected from the Ministry of Health's Information Centre. The isolation of communities made it difficult in some cases to assess the quality of health care services in depth.

In addition, there was the problem of limited available data and information systems on assessing access delay and the denial of medical teams. With the exception of PRCS, very few health care providers constantly track medical access incidents that can be used in the analysis of vulnerable communities. OCHA covers available humanitarian incidents but analysis is not carried out on a case by case basis and health is only one part of incidents documented. In fact, field workers had to follow up with health care providers regularly to encourage them to document such cases. The culture of detailing access incidents in health is apparently not a priority for health care providers. Efficient health information systems that relate health to human rights are still missing in Palestine.

Finally, field workers faced difficulties when collecting information on primary health centres and mobile clinics. There were constant delays in receiving information, which was at times not coherent and had to be re-compiled as well as re-entered several times when service provision, quality and policies for mobile clinic vary from one provider to the other. Moreover, the coordination and organization of focus groups were not particularly easy tasks to accomplish.

HDIP Health, Development, Information and Policy Institute

Map (1)
The path of the Wall in the West Bank - February 2005



Introduction

In the summer of 2002, the Israeli government began constructing its "Separation Barrier" in the West Bank, a complex system of electrified fences, patrol roads and cement Walls that dramatically deepens and consolidates the fragmentation of Palestinian lands, lives and livelihoods wrought by existing Israeli settlement construction and closures. Though it was declared illegal in an advisory opinion by the International Court of Justice (ICJ), July 9 2004,[4] construction of the Wall has since accelerated, including a Second Phase cutting as far as 22 km into the West Bank.

By isolating and fragmenting local health care networks and referral systems, as well as inducing economic hardship[5], aid dependency and vulnerability, the Wall poses a systemic challenge to Palestinian health care provision. Along phases officially approved by the Israeli government to date, it directly affects the health care provision of around 425,000 people, constituting 20% of the population of the West Bank.[6] This includes 12,750 elderly people, 183,000 youths below the age of 15, around 77,000 children under the age of five requiring periodic vaccinations, 24,225 chronic disease patients and 12,750 disabled people needing specialized health care and rehabilitation.[7]

The whole structure of barriers (see Map 1) creates or will create[8] 28 enclaves isolating 41 primary health care clinics either located between the Wall and the Green Line, or surrounding them completely by the Wall only, or surrounding them completely by the Wall and other structures such as settlement roads, checkpoints, gates and barriers. To date, around 70,500 Palestinians living in 22 communities have been stranded between the constructed parts

of the Wall and the Green Line border between Israel and the West Bank or surrounded completely by the Wall and other barriers.

The system of fences and walls jeopardizes the ability of existing primary health clinics in these isolated areas to maintain service coverage in their communities, especially when the construction is complete. As indicated in Table 1 below, 7 communities in 4 different enclaves with a total population of 5,335 will have no access to any type of health care services.

Table 1: Isolated communities with no access to health care services

District	Number of enclave	Population	Number of communities	Name of communities
Qalqiliya, Salfit and Ramallah	Enclave 11	115	4	Dar Abu Basal, 'Izbat Abu Adam, Khirbet Susa, wadi Qana
Jerusalem	Enclave 21	2,420	1	Az Za'ayyem
Bethlehem	Enclave 22	1,665	1	Al Walaja
Jerusalem	Enclave 28	1,135	1	Qalandia village
Total		**5,335**	**7**	

Along the Wall's completed First Phase and under construction of the Second Phase:

- Rapid and effective emergency care is becoming increasingly inaccessible, particularly in the north western Jenin enclave 1 and south of Qalqiliya enclaves 6 and 9. All referral systems based around the cities of Qalqiliya, Tulkarem, Nablus, Bethlehem, Jerusalem and Hebron have been severely obstructed. Enclaves

[4] "The Court finds that the construction by Israel of a wall in the Occupied Palestinian Territory and its associated regime are contrary to the International law, it states the legal consequences arising from that illegality." http://www.icj-cij.org/icjwww/ipresscom/ipress2004/ipresscom2004-28_mwp_20040709.htm

[5] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Implications of the February 2005 Projected West Bank Barrirer Route, February 2005, p.1 and The Humanitarian and emergency policy group (HEPG) and the Local aid coordination committee (LACC), the impact of Israel's separation barrier on affected communities, update number 3, November 30, 2003.

[6] Not accounted for by these figures is the population potentially affected by the Wall's eastern "Jordan Valley" segment, construction of which has been suggested but hitherto postponed by the Israeli government. See Map 4. However, these figures include the affected Palestinian population of Jerusalem.

[7] Sources for percentages of elderly people (3%), children under the age of 15 (43%), children under the age of five requiring periodic vaccinations (18.1%), chronic patients (5.7%) and disabled people (3%) are from the Palestinian Central Bureau of Statistics (PCBS).

[8] Parts of the Wall in the West Bank has been constructed while other parts are planned and under construction

north and south of Qalqiliya lack health facilities and along the First Phase seven communities with 3,950 inhabitants have no access to health care facilities inside their enclaves.

- Access to preventive services is severely impeded, especially pre-natal and post-natal care. In the absence of appropriate home deliveries and movement restrictions, the rate of delivery complications has increased. In fact, the Ministry of Health estimated in 2002 that 117,600 pregnant women, including 17,640 high-risk pregnant women will experience difficulties in accessing, or may not be able to access antenatal care, hospital delivery services and postnatal care.[9] Screening services are minimal in all isolated clinics, with the Tulkarem area being the worst affected. Well Baby clinics in the Qalqiliya and Jenin areas are particularly scarce, and the provision of vaccination services in these districts is also limited.

- Access to medication is becoming a significant problem in Jenin, south of Qalqiliya and villages around Jerusalem. In several clusters, 35% of clinics are unable to provide medication to their communities. Medical procurement problems due to access difficulties will likely force pharmacies in isolated communities to build larger stocks. If this happens, quality control procedures will need to be enhanced in these areas and more rational use of drugs encouraged.

- Access to speciality services is highly restricted. Seventy-three percent of isolated clinics do not provide speciality services and none of the clinics in the Jenin area provide services for patients with diabetes. In the district of Qalqiliya, enclaved communities have no access to ophthalmology, gynaecology, paediatric, or dermatology services. Diabetes patients and those seeking physiotherapy services are served by just one clinic, respectively.

- The Wall will increase reliance on local nurses and health workers that are poorly prepared for this responsibility, in the place of trained physicians. Only 32% of doctors live in the same village as their clinic or in nearby villages within the same cluster, compared to 90% of health workers living in the same village or the same area or cluster. But 68% of isolated clinics provide no continuous education for their permanent staff; the Qalqiliya and Bethlehem districts are particularly lacking such programmes.

- There is an urgent need for the provision of lab facilities. Only 35% of local clinics provide basic lab tests, but these are unevenly distributed. For example, only two clinics found in the cities of Qalqiliya and Tulkarem provide advanced lab tests and there are no laboratory facilities in Jenin district serving communities isolated by the Wall.

Clinics isolated by the Second Phase will soon face the same problems encountered by clinics already isolated by the Wall's First Phase since 2003. In terms of vulnerable health infrastructure and programmes, the most affected areas will be Cluster 1 Barta in Jenin, Cluster 5 Habla, and Cluster 9 Azoun 'Atma in Qalqiliya, Cluster 15 Latroun Area and Cluster 17 Beit Iksa Area in Ramallah, Cluster 18 Bir Nabala Area in Jerusalem, and Cluster 24 Bethlehem Area.[10]

Access of medical staff to their work place and patients to health care facilities is still a problem. Between January 2004 and April 2005, there has been a minimum of 375 cases of reduced and denied access for medical staff with an average delay of 62 minutes.[11] In the Wall area specifically, 157 cases of access prevention and delay have been reported; among which 18 cases were mobile clinics attempting to access isolated villages through Wall gates: 15 cases were prevented from reaching isolated communities and 3 cases were delayed for several hours. Manned checkpoints and gates were responsible for these delays and from preventing medical staff from reaching communities and patients from receiving health care services.

The most vulnerable communities in terms of medical teams facing greatest access difficulties were those in clusters isolated by the Wall in Jenin and south of Qalqiliya: the Barta'a Ash Sharqiya cluster 1, Ras Tira cluster 5, Habla cluster 6 and Azoun 'Atma cluster 9. Clusters isolated by the Second Phase in Bethlehem area are expected to face the same serious access problems when construction is complete.

Two years have passed since the construction of the Wall and little, if any progress, in the development of the health sector has occurred within affected areas. Despite a serious concern with linking the tasks and strategies of emergency relief work to developmental perspectives, the prevailing trend over the past two years has been characterized by an intensive focus on relief activities and scattered initiatives to solve temporary access problems faced by medical teams and patients.

[9] Palestinian Ministry of Health (MoH), Annual Report, 2002.
[10] For more details about the degree of vulnerability and specific health areas, refer to Section Two.
[11] Data has been collected through HDIP's field work and incident reports from the Ministry of Health (MoH), NGOs, the United Nation Relief and Work Agency (UNRWA) and the Office for the Coordination of Humanitarian Affairs (OCHA).

Some health care providers prolonged their working hours. New health centres were created to serve communities that have been isolated from other health facilities. For example, a new governmental primary health care clinic in Aqaba was established in 2004 to serve the 1200 inhabitants of Ad Daba, 'Arab Abu Farda, Ras at Tireh and Arab ar Ramadin south of Qalqiliya city who had no access to health services after the construction of the First Phase.

Moreover, the Ministry of Health and NGOs adopted a more decentralized approach in implementing their daily medical activities to overcome the recurrent access problems. Cooperation between national and international organizations, such as UNICEF, WHO, ICRC and international NGOs has increased in isolated areas in order to facilitate drug distribution to rural clinics when access of Palestinian medical teams is denied. Some NGOs increased the level of their primary health care centres to become mini-emergency hospitals covering a wider geographical range of rural areas. In addition, some training courses of health professionals with the provision of medical equipment were organized. Other simple training courses targeted women and midewives in isolated villages.

The most apparent strategy adopted by health care providers was running general and specialized mobile clinics serving isolated communities. However, the duration of such activities is dependant on funding opportunities and hence limited. On the other hand, access to primary and specialized health services as well as medication, are significant problems facing affected communities and cannot all be solved by mobile clinics in the long term. Moreover, disabled individuals and chronic disease patients needing treatment in Jerusalem will be greatly impacted.

These problems impose an additional burden on Palestinian health service providers. Many have responded by increasing and dispersing facilities and staff and are already resorting to similar strategies to prevent a further deterioration in service coverage in areas impacted by the Wall. Limited financial and human resources raise doubts as to the longer-term sustainability of this strategy.

If the structure of the Wall continues as planned, it will result in a new geography of segregation for the West Bank, where the southern part (Hebron and Bethlehem District) is separated from the already enclosed communities in the north, Jerusalem is already isolated from the West Bank and the eastern part of the Jordan valley will be separate from other areas as well. This separation is forcing decision makers and planners to develop health services in response to the isolated clusters, resulting in a fragmented approach which is inefficient on a long-term as it will affect deeply the strategic planning and development on a national level. The resulting fragmentation of national development and policy issues might lead eventually to the disintegration of national institutions.

International humanitarian aid continues to provide vital support to the Palestinian health system. Temporary measures like the operation of mobile clinics in isolated areas complement fixed health infrastructure, where this proves to be insufficient and/or difficult to access.

In order to avoid an erosion of the existing health structures, the emergency approach should be complemented by a mid- and long-term approach of health development, especially focusing on the sustainability of the existing infrastructure.

Health and the Wall in numbers

- Created Enclaves:
  28 Enclaves
- Isolated clinics:
  41 Primary Health Care clinics
- Affected population:
  425,000 Palestinians
- 34,318 people will not have access to sufficient health services.
- 5,335 people in 7 communities will not have access to any health care services.
- 6,000 people will not have any vaccinations, general practitioner, preventive dentistry, and laboratories to perform simple tests.
- 79,320 people (excluding east Jerusalem) will not have access to emergency care, specialized consultations, general medicine, x-ray service, and other curative medical services.
- 79,320 people will no longer be able access hospital services.

Section One

Mapping the Wall & Access Policy

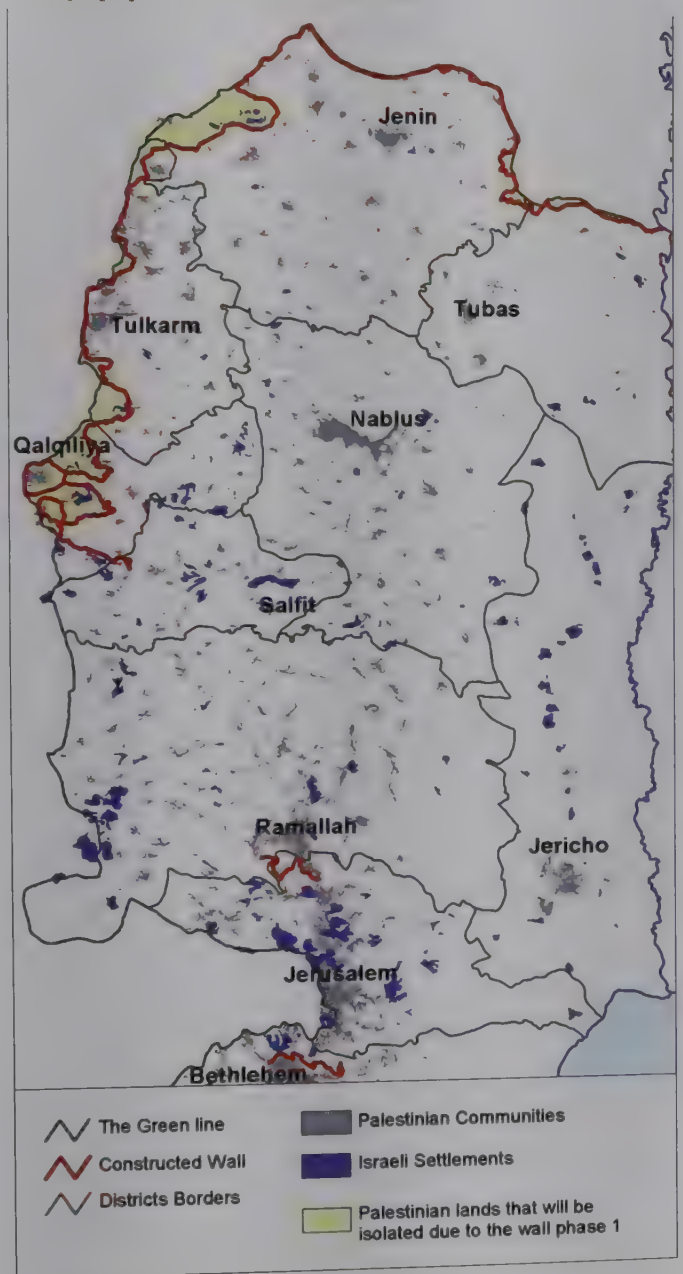
1. Context: The Wall since 2004

Israel's government began constructing the First Phase of a "Separation Barrier" in June 2002, clearing land along a 157 km swatch in the West Bank districts of Jenin, Tulkarem and Qalqiliya (see Map 2). As part of this First Phase, construction also began on a 20 km stretch of fence and Wall skirting the edges of southern Ramallah, northern Bethlehem and East Jerusalem, part of what is referred to as the "Jerusalem Envelope" and which will de facto integrate 90% of the West Bank district of Jerusalem into Israel.

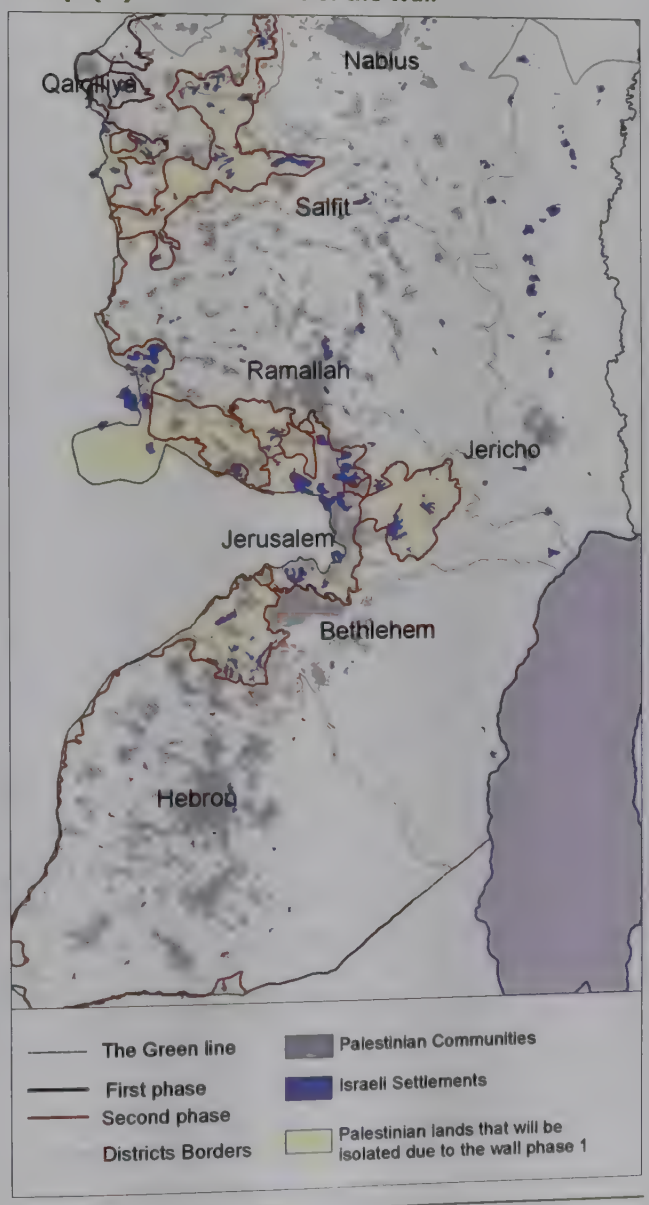
Beginning in March 2003, the Israeli government began releasing plans for the Second Phase throughout the West Bank districts of Salfit, Ramallah, Jerusalem, Bethlehem and Hebron (see Map 3). Since then 225 km out of 675 km have either been completed (First Phase and parts of the Second Phase) or are under construction (Second Phase), not including a recommended Eastern Segment, approval for which is currently on hold. This Eastern Segment would sever the entire Jordan Valley from the heart of the West Bank (see Map 4).[12]

Including the 28 enclaves, the West Bank will be divided into an additional five main parts separated from each other: **1)** the north and the middle including the districts of Jenin, Nablus, Qalqiliya, Tulkarem, Salfit, Tubas and Ramallah, **2)** villages located within the northern area in between Salfit

Map (2): First Phase of the Wall

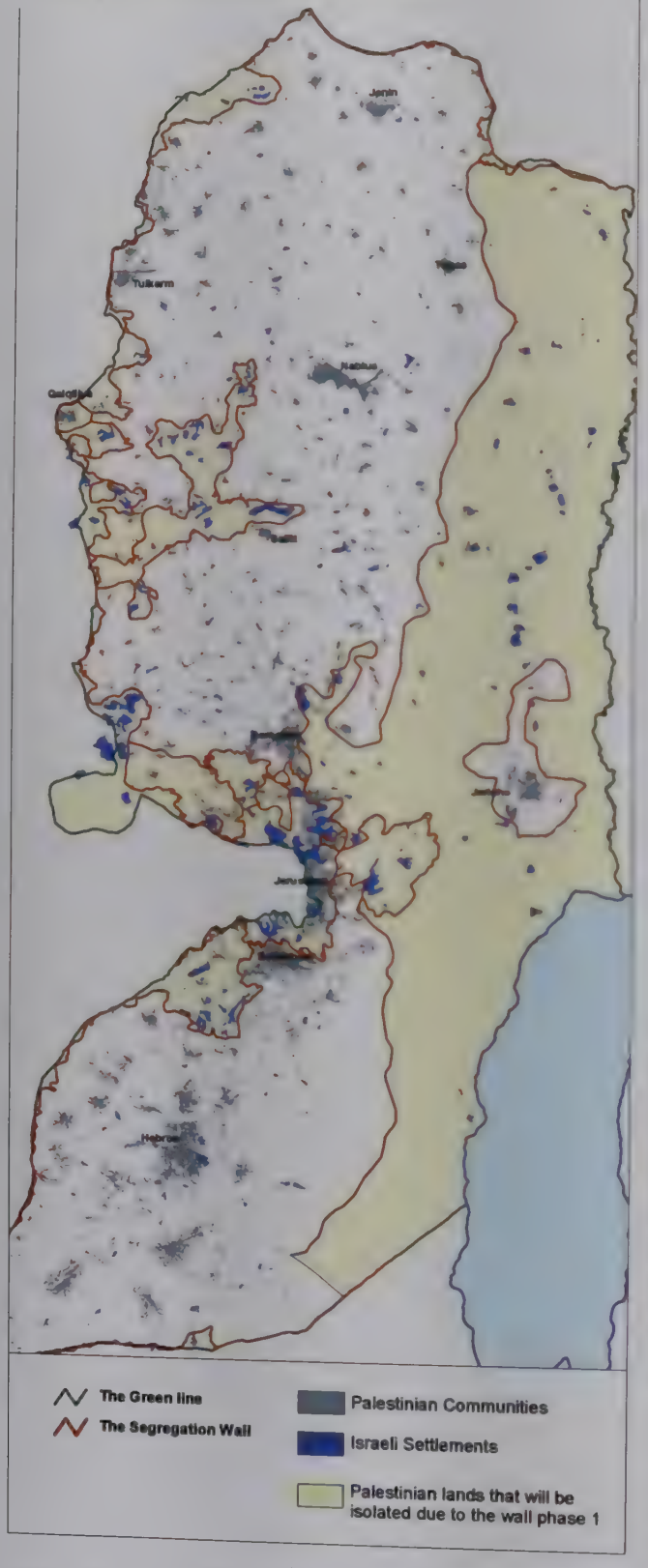


Map (3): Second Phase of the Wall



[12] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Implications of the February 2005 Projected West Bank Barrirer Route, February 2005, p 1

Map (4): The entire path of the Wall



Map (5): Israeli settlements in the West Bank

and Qalqiliya **3)** the south including the districts of Bethlehem and Hebron **4)** Jericho and **5)** Jerusalem (see Map 6). Map 7 highlights the trend of separating Palestinian communities in the West Bank.

2. Changes in the path of the Wall

The Israeli Ministry of Defence published several projections of the path of the Wall in the West Bank. On 30 June 2004, the Israeli Ministry of Defence published slightly a revised map for its path, decreasing the total length of the Wall by 15 km as per earlier plans published on 23 October 2003 and 25 March 2004, thus increasing the proportion located on the

Map (6): West Bank divided into clusters

Green Line by 5%. In several other areas, the Wall's path has been modified to enclose fewer Palestinian communities and Israeli settlements. However, these modifications have, in some places, further severed Palestinian access to cultivated land, and risked more

communities turning into enclosed areas, most notably in the western Bethlehem district.[13] As elsewhere, the path of the Wall in Jerusalem and in the Hebron area may be subject to further revision.

During the writing of this report, the GoI altered the path of the Wall for the fourth time and issued a new map on 20 February 2005,[14] altering prior routes published in 23 October 2003, 25 March 2004 and 30 June 2004 as indicated in the series of maps number 8.

3. Creation of vulnerable population clusters

Combined with the existing network of bypass roads, checkpoints, gates and roadblocks[15], the Wall encloses and isolates a total of 28 clusters or enclaves of Palestinian communities along its First and Second Phases, as shown in Map 9. These clusters often comprise vulnerable communities with inadequate health and social infrastructure that are isolated from other communities in the West Bank and supported by a limited number of governmental, Non-Governmental Organizations (NGOs) and UNRWA service providers[16].

In this report, such clusters were categorized according to three main typologies: Behind the Wall, Complete enclosure by the Wall and Complete Enclosure by the Wall and other structures.[17] The specific type of enclosure is not considered as an indicator of the Wall's impact on access to health care services because Palestinians living within these different clusters will all experience similar access problems regardless of the typology. However, it is important to pioneer this typology as a means to understand the impact of closures.

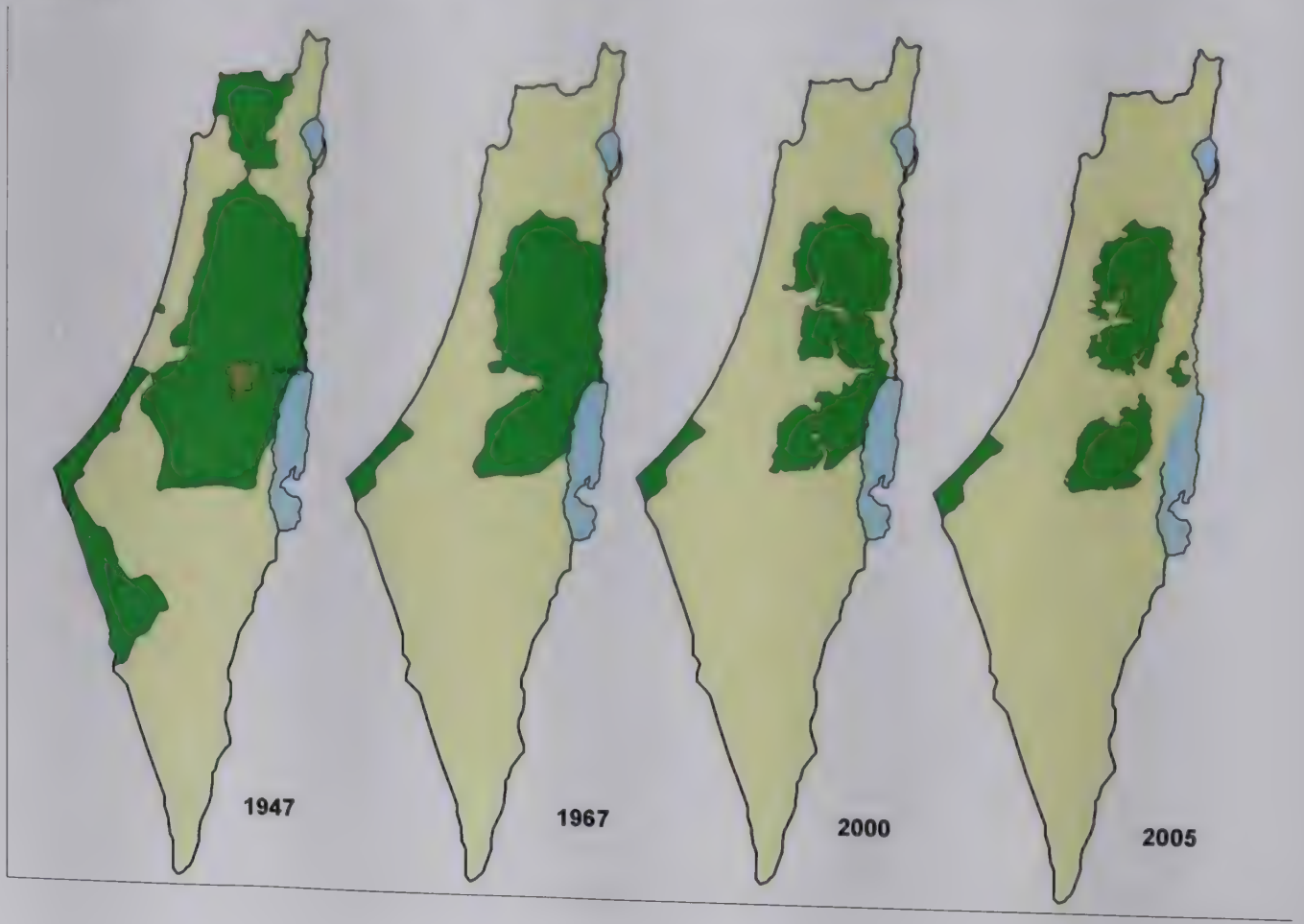
[13] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Impact of the West Bank Barrier on Palestinian Communities, 1 September 2004, Update No.4, p.2.
[14] This map can be found at http://www.securityfence.mod.gov.il/Pages/ENG/default.htm.
[15] According to the United Nations Office for Coordination of Humanitarian Affairs (OCHA), "the West Bank closure system compromises over 600 physical barriers placed by the Israeli Defence Forces (IDF)", West Bank Closure and Access Report, April 2005, www.ochaopt.org.
[16] The impact of the Israeli Separation Barrier on Affected West Bank Communities: A Follow Up Report to the Humanitarian and Emergency Policy Group (HEPG) and the Local Aid Committee (LACC), update number 1, 31 July 2003, pp. 9-10.
[17] Enclave 19 that includes East Jerusalem was not classified according to these typologies; instead it was taken as a separate case. Six clinics are located within this enclave and were considered in our analysis of health facilities. Refer to further sections and Annex 3 & 4 for more information about the capacities of health infrastructure and the population affected in clusters within this classification

Forty one clinics are located within these clusters: 1 clinic (2%) in Jenin, 9 clinics (22%) in Qalqiliya, 3 clinics (7%) in Salfit, 4 clinics (10%) in Ramallah, 18 clinics (44%) in Jerusalem and 6 clinics (15%) in Bethlehem (See Map 10).

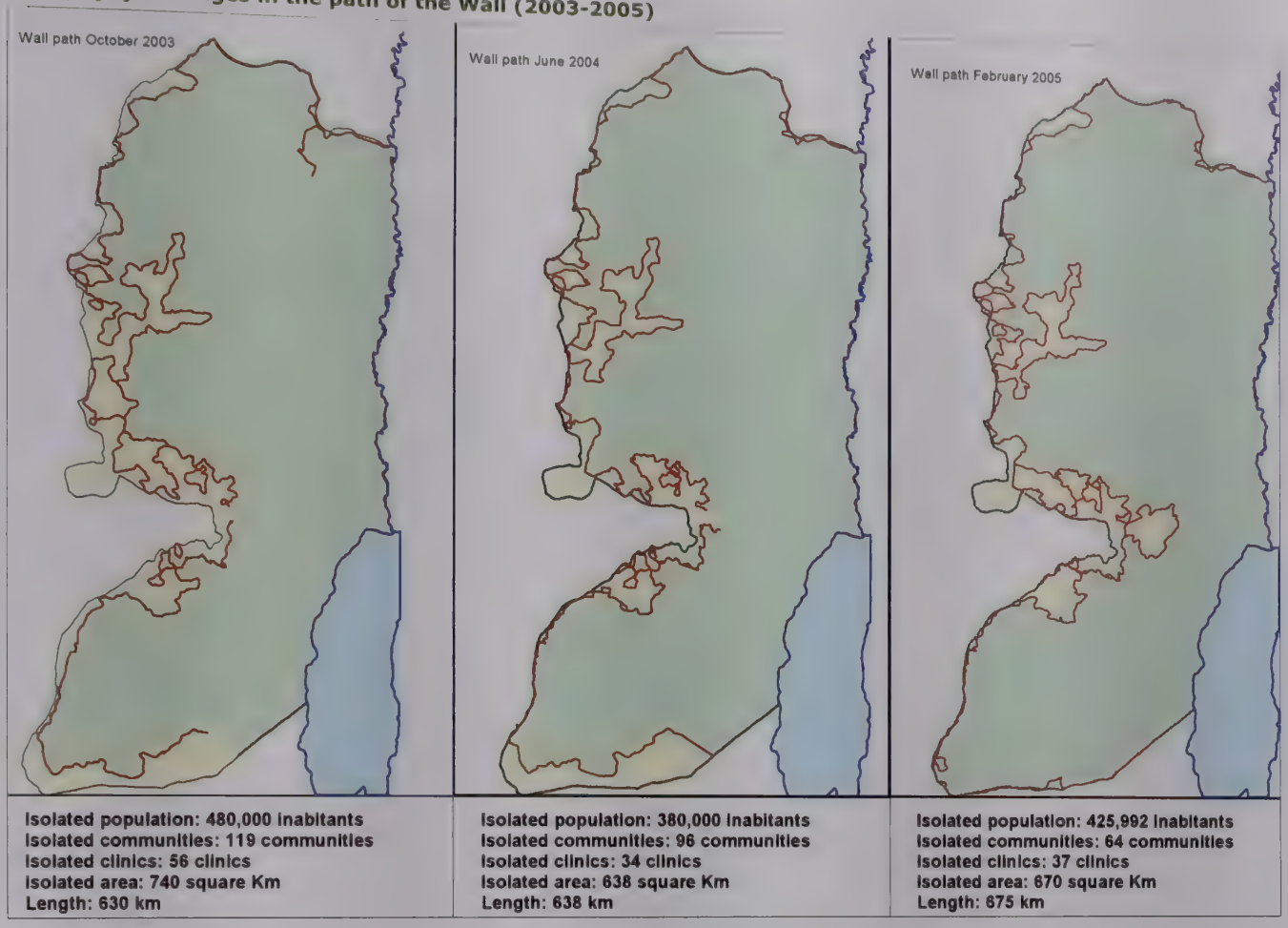
Distribution by health provider was as follows: 23 (56%) governmental facilities, 15 (37%) managed by NGOs (among them two are joint clinics run by the Ministry of Health and NGOs), 2 (5%) by UNRWA and one (2%) private clinic.

Graph 1: Number of isolated clinics by the Wall's First and Second Phases

Map (7)



Map (8): Changes in the path of the Wall (2003-2005)



Behind the Wall

The First and Second Phases of the Wall have created, or will create, twelve clusters in between the Wall and the Green Line, cutting them off from the rest of the West Bank. As shown in Map 9, these are clusters 1,2,3,5,7,8,12,13,14,25,26 and 27 which include 11 communities of around 5,000 Palestinians. Access to other communities in the West Bank is mainly through gates at the entrance of each cluster. One clinic only - the Bartaa Ash Sharqiya governmental clinic - is isolated in cluster 1.

Complete Enclosure by Wall

The current and projected itinerary of the Wall will create eight clusters of isolated Palestinian communities completely surrounded by the Wall including clusters 4, 6, 9, 18, 21 and 23 in Map 9. Controlled through means of gates or checkpoints, Palestinians affected in this way comprise 9 communities of around 70,000 people.

Within these clusters lie 11 clinics: 9 clinics (82%) in Qalqiliya, 2 clinics (18%) in Jerusalem. When distributed by operating organization, it emerges that 8 clinics (73%) are run by the MOH, and 3 clinics (27%) by NGOs.

Complete Enclosure by Wall and other structures

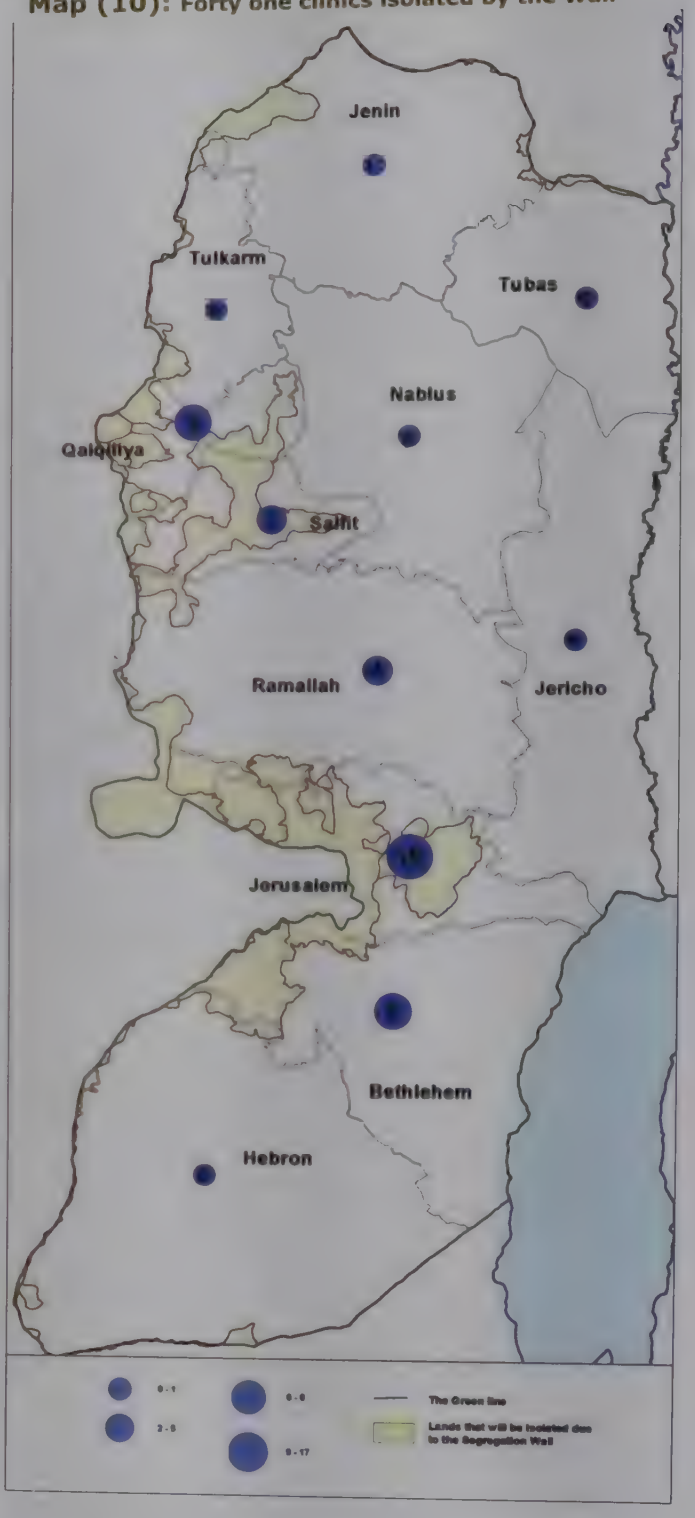
Seven clusters (10, 11, 15, 16, 17, 20, 22, 24 and 28 in Map 9) will be surrounded by the Wall and settlement roads or other "security routes" or "temporary paths".[18] Although these clusters are not completely surrounded by the Wall and will not be controlled by guarded gates, they will be bordered partially by the Wall and other structures. These structures include roads reserved for settlers use which are, in all cases, prohibited for Palestinian use therefore acting as a further barrier along the Wall, and checkpoints that completely enclose and surround adjacent communities in separate clusters.

Twenty-three clinics are located within these clusters: 3 clinics (13%) are in Salfit, 11 clinics (48%) in Ramallah, 3 clinics (13%) in Jerusalem and 6 (26%) in Bethlehem. Fourteen (61%) are run

[18] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Impact of the West Bank Barrier on Palestinian Communities, 1 September 2004, Update No.4, p.2

Map (9): Creation of 28 vulnerable enclaves

Map (10): Forty one clinics isolated by the Wall



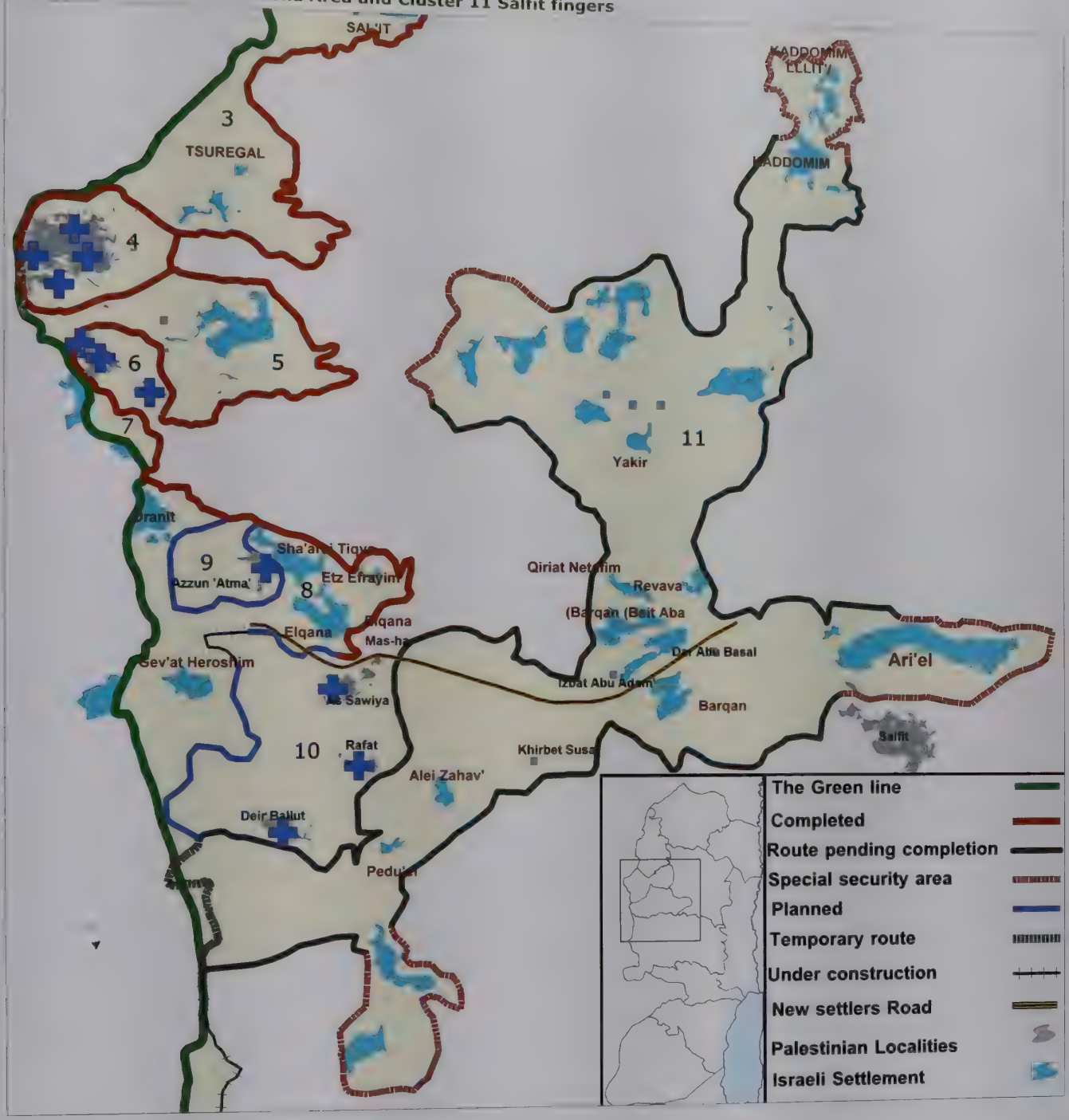
by MOH, 1 clinic (4%) run by UNRWA, 6 clinics (26%) by NGOs, and 2 joint clinics (9%).

All these clusters include 33 communities of 91,188 people and are classified as follows:

Cluster 10 Masha Area

As shown in Map 11, the Wall will carve out a cluster of three Palestinian communities of 12,560 people in the district of Salfit served by 3 primary health care clinics. The new settlement road, which is under construction, will run across the open side of the Wall path connecting Ariel settlement with Israel and will be forbidden for the use of Palestinians, thereby cutting off these three communities from the rest of the West Bank.

Map (11): Cluster 10 Masha Area and Cluster 11 Salfit fingers



Cluster 11 Salfit Fingers

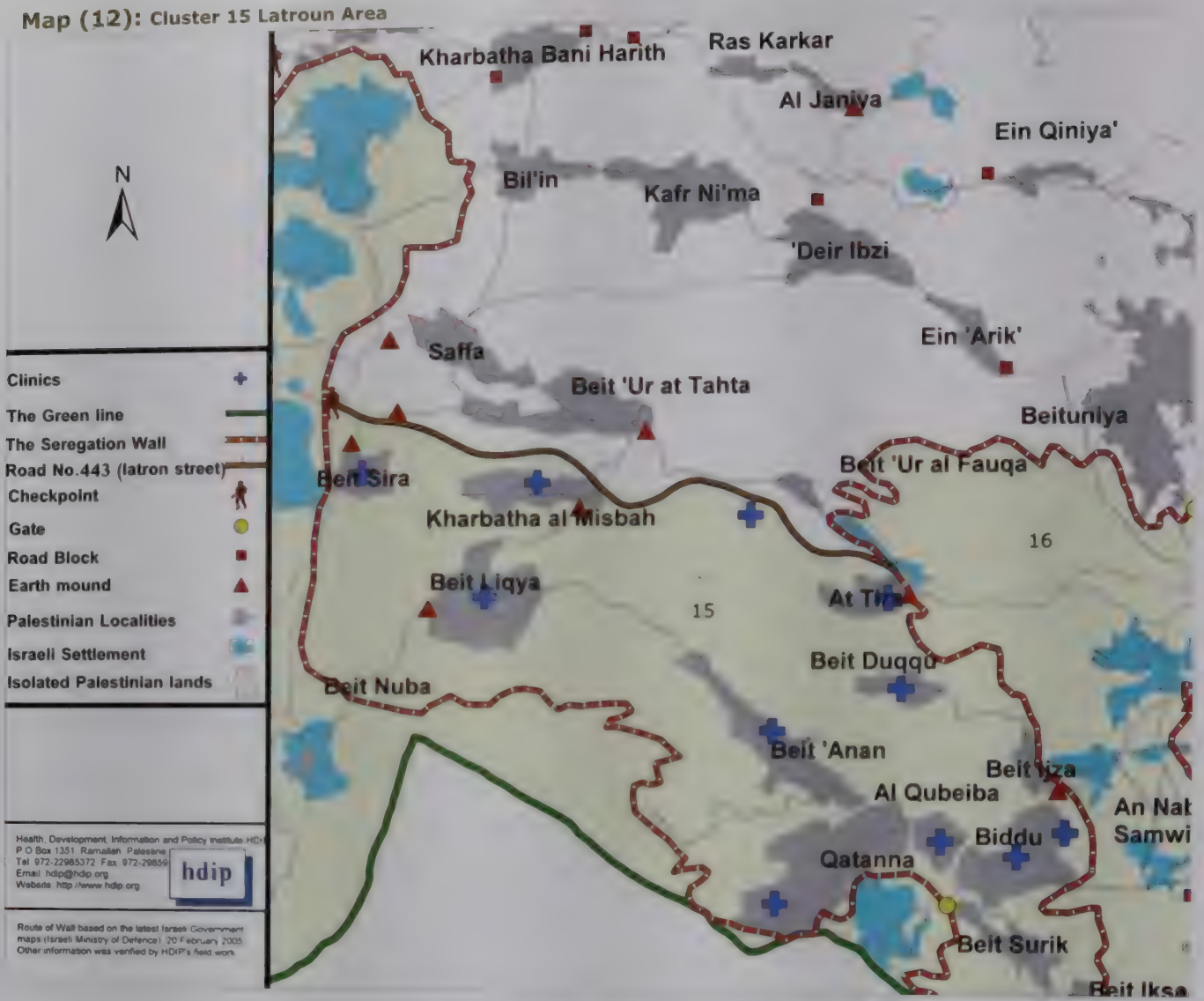
Map 11 shows that the GoI has also added two new definitions to its revised route in the Salfit district: "Special Security Area" and "Route Pending Completion". These areas are mainly situated within the Ariel settlement fingers where requisition orders have been issued and construction has already begun.[19] According to HDIP's field work, the current construction work in these "Special Security Area and "Route Pending Completion" is exactly like that in other places where the Wall has been built. Around 120 Palestinians in 4 communities will have no access to any health care services inside this cluster, with the exception of mobile clinic activities.

Cluster 15 Latroun Area

The highway road 443 connecting north western Jerusalem to Tel Aviv is forbidden for Palestinian use (see Map 12). All other Palestinian roads connected to this highway have been closed. As a

[19] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), Preliminary Analysis of the Humanitarian implications of February 2005 Barrier projections, February 2005, Update No.3, p.3

Map (12): Cluster 15 Latroun Area



result, fourteen communities (42,460 inhabitants) will be cut off from the rest of the West Bank and served by 11 PHC clinics. A tunnel controlled by Israeli soldiers connects the villages of Beit 'Ur At Tahta with Kharbatha al Misbah that have been severed by this highway.

Cluster 16 and 17 Beit Iksa Area

Served by only one governmental PHC clinic, 1,760 Palestinians from Beit Iksa and An Nabi Samuwil are not allowed to travel to Bir Nabala and cannot enter Jerusalem. As shown in Map 13, they are enclosed in an enclave, surrounded by settlements and separated from other areas by a "temporary route", a completed, planned and under construction path of the Wall.

Cluster 20 Shu'fat and Anata Area

According to Israeli maps, "a temporary path" of the Wall will be built in this area, creating an enclave around Anata village and Shu'fat refugee camp. Moreover, this temporary route will isolate Az Za'ayyem village within the Malee Adumim settlement in cluster 21 (see Map 13). Only two PHC clinics will serve the 13,500 inhabitants of Shu'fat Camp and Anata, whereas Az Za'ayyem village will have no access to health care services.

Cluster 22 and 24 Bethlehem Area

As shown in Map 14, villages in cluster 22 and 24 will be surrounded by the Wall and a settlement or "protection road" forbidden for the use of Palestinians. Not only will the settlement road separate them from the cities of Bethlehem and Beit Jala a few kilometres away, it will also create enclosed enclaves within enclaves. The 1,665 inhabitants of Al-Walaja village in cluster 22 will be separated from the nearby villages in cluster 24 and

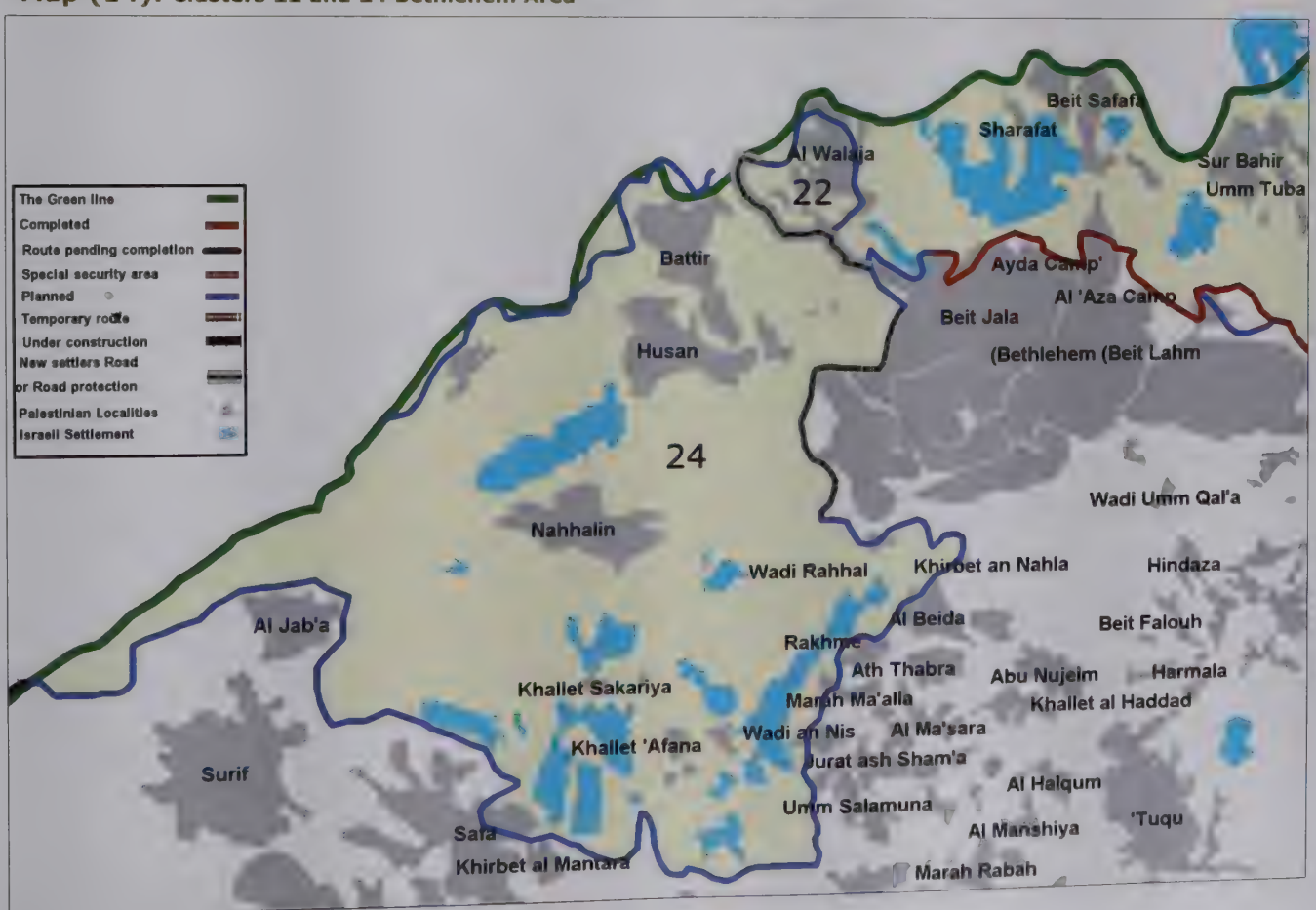
will have no access to health care services. In cluster 24, the 18,048 residents of Battir, Husan, Nahhalin, Khallet 'Afana, Wadi Fukin, Khallet Sakariya and Khallet al Balluta that are served by 7 clinics will be lacking secondary and specialized health care services usually obtained from Bethlehem.

Cluster 28 Qalandiya village Area

According to Israeli maps, a "protection road" will separate Qalandiya village with its 1,135 residents from Qalandiya camp outside the Wall and from all nearby villages isolated inside the Wall (see Map 13). If this occurs, villagers will no have access to any health care services.

Map (13): Clusters 16 and 17 Beit Iksa Area / Cluster 20 Shu'fat and Anata Area

Map (14): Clusters 22 and 24 Bethlehem Area



4. Access for medical teams and patients

According to the Humanitarian and emergency Policy Group (HEPG) and the Local Aid Coordination Committee (LACC), the Wall "could effectively isolate Palestinian communities from their economic and social means of support - further exacerbating the process of economic fragmentation associated with the current internal closure and curfew regime"[20]. Some 55 gates have been built into the completed portion of the Wall: Only 21 are open to Palestinians who have permits[21], albeit irregularly two or three times a day, and for short durations typically for periods of an hour and a half. In the entire Tulkarem governorate only 4 out of 11 existing gates are open. Across the northern West Bank, many Palestinian farmers now have to travel 10-15 kilometres every day to reach land immediately adjacent to their communities.

On 2 October 2003, the Israeli army also issued a military order no. 378, declaring all occupied West Bank land between the Wall and Israel's 1967 border a "Closed Zone." Palestinian residents and farmers must now obtain a bewildering range of permits, inter alia to remain in or enter this seam zone, to transport produce, or use mechanized vehicles or agricultural implements. As a rule, such permits are rarely granted. In the Tulkarem village of Qaffin, 30% of the village's land now lies behind the Wall, and of the 1,400 (out of 10,000 residents) who have applied for entry permits to access that land; only 17 had been granted.

Medical staff and international humanitarian organizations also have to apply for permits to enter the seam zone and there are numerous examples of ambulances and health care professionals having been prevented from reaching isolated communities, as they refuse to apply for permits. According to Palestinian medical organizations and health professionals, requesting permits to travel within the West Bank in order to provide health care is against the Fourth Geneva Convention of 12 August 1949,[22] relating to the protection of the civilian population in time of war and the provision of basic services.

When considering access problems faced by medical teams and patients, the reality of the Wall should not be separated from the general closure measures imposed on Palestinian communities. The Wall hinders health workers, medication, medical supplies and equipment from reaching vulnerable communities. Equally, patients living in isolated clusters constantly face difficulties in accessing basic and specialized health care. However, a more holistic approach to access to health care services should be examined within the existing "new geography" of the West Bank: the separation of rural areas from urban centres, the separation of Jerusalem from the West Bank and Gaza, as well as the separation of the West Bank from Gaza. A variety of barriers routinely impede the access of medical staff and patients not only in areas where the Wall is planned, under construction or completed, but throughout the West Bank and the Gaza Strip.

More specifically, there are five types of access difficulties throughout the West Bank, the Gaza Strip and in areas affected by the Wall:

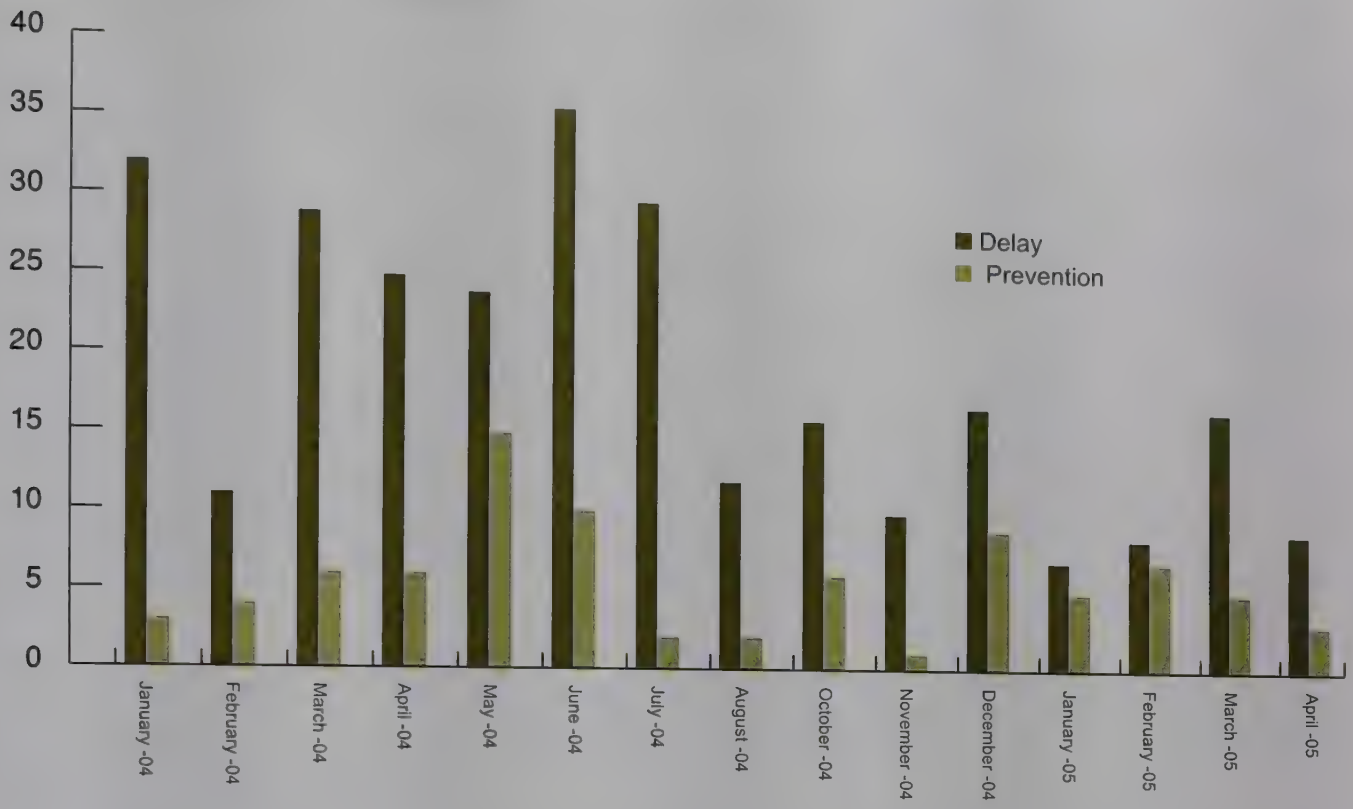
- Patients' access for basic and specialized health care services;
- Access of medical staff to their clinics;
- Access of ambulances carrying patients in critical situations;
- Access of medication, vaccinations, medical equipment, etc; and
- Access of mobile clinics to isolated villages.

Reports on incidents of access denial and delays were difficult to obtain for the purpose of this report. However, HDIP managed to gather as much information as possible through field work and incident reports from the Ministry of Health, NGOs, the United Nations Relief and Works Agency (UNRWA) and the Office for the Coordination of Humanitarian Affairs (OCHA).

Analysis of available data reveals that between January 2004 and April 2005, there have been 375 reported

[20] The Humanitarian and emergency policy group (HEPG) and the Local aid coordination committee (LACC), the impact of Israel's separation barrier on affected communities, update number 3, November 30, 2003, p.7.
[21] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Impact of the West Bank Barrier on Palestinian Communities, 1 September 2004, Update No.4, p.2.
[22] http://www.icrc.org/ihl.nsf/0/6756482d86146898c125641e004aa3c5?OpenDocument

Graph 2: Access incidents in the West Bank and Gaza



cases of reduced and denied access for medical staff with an average delay of 62 minutes. Graph 2 shows access difficulties rose during the period May 2004 - July 2004.

In the Wall area specifically, 157 cases of access prevention and delay have been reported; among which 18 cases were mobile clinics attempting to access isolated villages through gates: 15 cases were prevented from reaching isolated communities and 3 cases were delayed for several hours.

Manned checkpoints and gates were responsible for these delays and from preventing medical staff from reaching communities and patients from receiving health care services. In 5% of cases, other reasons (e.g. settlers and security guards at hospital entrances) were mentioned for the delay of medical staff.

The most vulnerable communities in terms of medical teams facing greatest access difficulties were those in isolated clusters in Jenin and south of Qalqiliya.

More specifically, the Barta'a Ash Sharqiya cluster 1, Ras At Tira cluster 5, Habla cluster 6 and Azoun 'Atma cluster 9 have been the most seriously affected. Access to specialized health care continues to be difficult, especially for emergency and chronic cases. The time it takes villagers to travel to the other side of the Wall has increased significantly. Access of medical teams to these clusters have proved almost impossible without permits and in most cases, soldiers prevented mobile clinic teams from entering this area. For example, one PMRS mobile clinic team has been denied access eight times with delay of two to three hours. The only successful attempts have been those where internationals or Israeli medical organizations, such as the Israeli Physicians for Human Rights (PHR) organization, were with the medical teams.

Movement restrictions and destroying and cutting off cultivated lands, the Wall deepen the socio economic crisis being faced in the West Bank, and exacerbate the already fragile humanitarian situation[23]. According to World Bank estimates, the number of poor in the West Bank and Gaza has tripled to over 2 million since September 2000, comprising 60% of its population.[24] Over half a million Palestinians are now completely dependent on food aid, and studies have found that Global Acute Malnutrition (GAM) now affects 7.8% of all Palestinian children.[25]

[23] United Nations - Office for the Coordination of Humanitarian Affairs (OCHA), The Humanitarian Implications of the February 2005 Projected West Bank Barrirer Route, February 2005, p.1 and The Humanitarian and emergency policy group (HEPG) and the Local aid coordination committee (LACC), the impact of Israel's separation barrier on affected communities, update number 3, november 30, 2003.

[24] On the basis of a poverty line of $2.1 per day according to the World Bank estimates

[25] Nutritional Assessment of the West Bank and the Gaza Strip, Al Quds University and John Hopkins University, 2003, p.9

Joint medical day at Barta'a Ash Sharqiya

Palestinian mobile clinic joined with Israeli Physicians for Human Rights Specialists

Barta'a enclave (enclave 1) is a village located between the Green Line and the Wall with entry to the West Bank through two gates and thereby 4,319 inhabitants require permits in order to reside or travel outside to the West Bank (see Map 15 below).

Also, the construction of a new settlement road prohibited for use by Palestinians implied that residents of Khirbet Munther Al Garbiya inside this enclosed area use tunnels to access other nearby villages. The residents of Daher Al Maleh are also unable to access Barta'a Ash Sharqiya and live in an enclave within an enclave.

The enclave is served by one governmental clinic. The Barta'a Ash Sharqiya clinic was established in 1984 and is open from 7:00 a.m. to 15:00 p.m. It is headed by a nurse from the village itself and a doctor who

Map (15): Barta' Asharqiya Enclave 1

lives in Nazlat Issa in the Tulkarem governorate, and makes weekly to bi-weekly visits to the clinic. The clinic has a pharmacy and provides health awareness and education to patients, chiefly concerning public health issues. However, it offers no specialized, family planning or screening services.

The clinic does have a maternal and child health programme, providing prenatal and postnatal services, and though the local nurse reports supervising home deliveries, she has no capacity to perform deliveries.

A major problem, exacerbated by the completion of the Wall, is that the clinic's physician does not live in the immediate area. In order to commute to work, they therefore have to negotiate passage east through one of the Wall's gates, pass several checkpoints on their way north, and cross the Wall westward. Prior to the Wall's construction, Israeli soldiers regularly delay them for hours at various checkpoints. The nurse holding the necessary permit to enter routinely experiences delays of up to 90 minutes at the gates, and reports that soldiers have previously strewn medicines on the ground during searches.[26] The clinic reports that even before the completion of the Wall, medical deliveries suffered constant delays because of checkpoints and curfews, taking as long as 35 days, and that immunization programmes had been pushed back by some 14 days. Internal closures have also obstructed clinical referrals and several babies have missed important vaccinations.

[26] UNRWA, Between a Rock and a Hard Place: Access to health care in the Barta'a Encalve, February 2004 and Profile: Barta'a Sharqiya Enclave - update, August 2004.

UNRWA and some Palestinian NGOs, such as PMRS and St. John's Eye hospital, organize medical days to the Barta'a Ash Sharqiya enclave as complimentary medical activities to the existing health facility that cannot provide all specialized health services to the population.

One example was the joined medical day organized by PMRS and Physicians for Human Rights on Saturday 30 April 2005. The Palestinian mobile clinic reaches the Barta'a Ash Sharqiya gate in the northern West Bank in the Jenin district but is not allowed to enter the enclave as the staff has no permits. This was not the first time that Palestinian medical teams have been rejected entry into Barta' Ash Sharqiya village. Local and international specialists from St. John's Eye hospital in Jerusalem were denied entry because they were not able to obtain permits.[27] UNRWA mobile clinics have also frequently been denied access to this area.

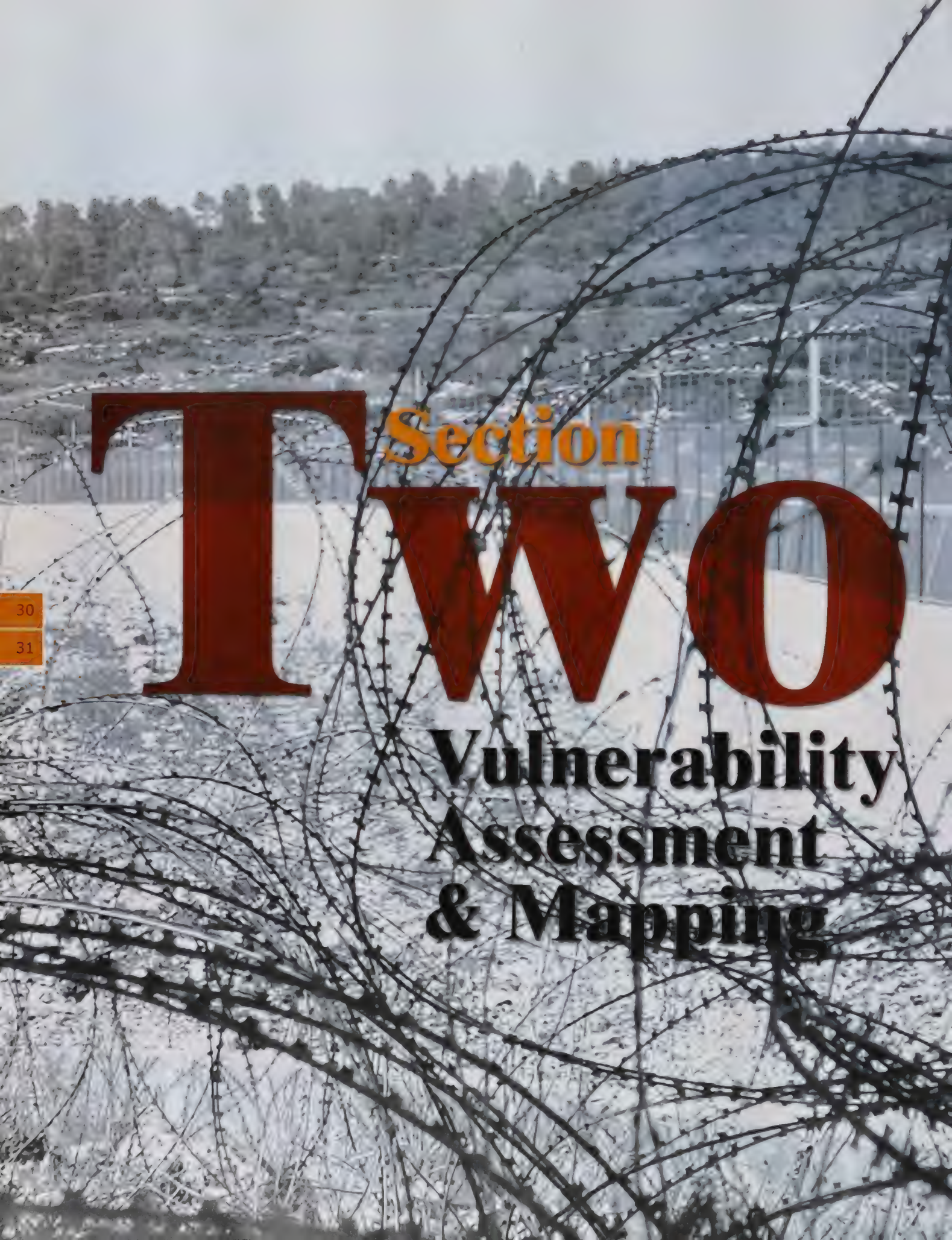
The PMRS mobile clinic team has only been permitted entry to the village once in the past, when it was accompanied by the Medico International representative. He coordinated with the Spanish Consulate, OCHA and ECHO, and effected the team's entry after a delay of several hours. Without this international support, it can be taken for granted that access could not be obtained by the medical teams.

As Israeli doctors join the Palestinian medical team, negotiation to enter the enclave starts and finally permission is granted. The joined mobile clinic team arrives in Barta'a Ash Sharqiya at 2:00 pm, and is greeted by dozens of queuing patients. The doctors, a General Practitioner, a gynaecologist, a paediatrician and an internal medicine specialist, set up their respective consultations. Health workers set up the pharmacy. More patients arrive until the clinic is completely full.

Fatima, one of the clinic's patients, expressed her opinion: "We look forward to these joint activities between Palestinian and Israeli doctors because at the governmental clinic, the doctor does not come everyday, and he is often prevented from entering the village by Israeli soldiers. I cannot leave the enclave because I have no ID, and therefore cannot obtain a permit or receive health care outside our village. My daughter went to hospital in Nablus and I could not go with her."

Many patients appreciate such initiatives and value the courage of Palestinian and Israeli medical teams, and of doctors that peacefully insist on their rights to access by waiting and negotiating to enter enclosed Palestinian areas in order to provide a basic right that applies to all human beings: health for all.

[27] UNRWA, Profile: Barta'a Sharqiya Enclave, update, August 2004

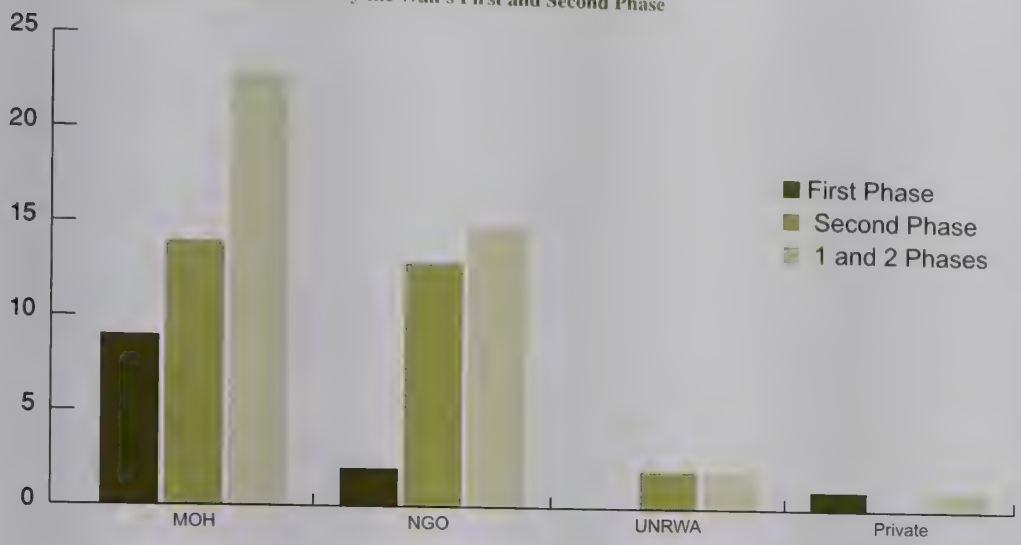


Section Two

Vulnerability Assessment & Mapping

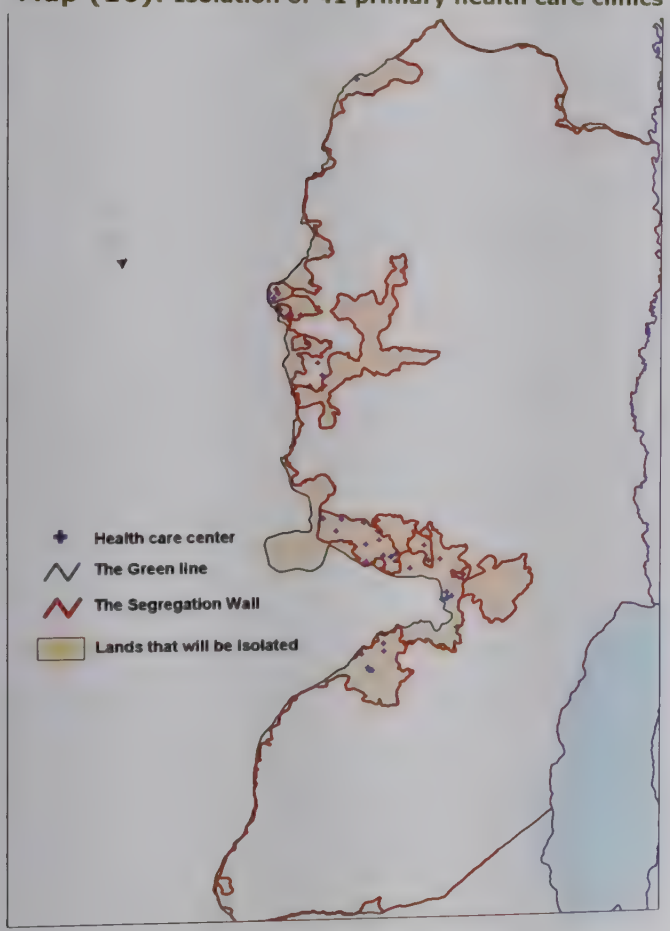
Compounded by checkpoints straddling major Palestinian roads, the system of barriers severely limits access to health care services along its First and Second Phases. In total, it isolates 41 primary health care clinics (see Map 16) of which 23 are governmental facilities, 15 are managed by NGOs, (2 being joint clinics between the Ministry of Health and NGOs), 2 are managed by UNRWA, and 1 is a private clinic.

Graph 3: Number of isolated clinics by the Wall's First and Second Phase



By isolating and fragmenting local health care networks and referral systems, as well as inducing aid dependency and vulnerability, the Wall poses a systemic challenge to Palestinian health care provision.

Map (16): Isolation of 41 primary health care clinics



To date, along phases officially approved by the Israeli government, the Wall directly prejudices the health care conditions of around 425,000 people, constituting 20% of the population of the West Bank. This includes 12,750 elderly people, 183,000 youth below the age of 15, around 77,000 children under the age of five requiring periodic vaccinations, 24,225 chronic disease patients and 12,750 disabled people needing specialized health care and rehabilitation.

Already, around 70,500 Palestinians living in 22 communities have been stranded between the constructed parts of the Wall and the Green Line border between Israel and the West Bank or surrounded completely by the Wall and other barriers (See Section I).

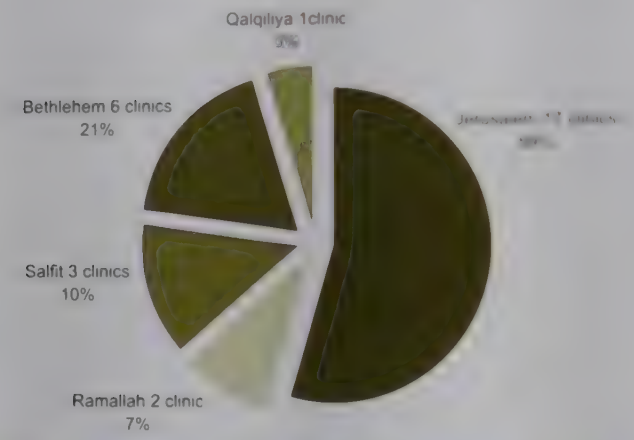
1. General assessment of health services along the Wall's Second Phase

In this section, we present an assessment of health services available to communities isolated by the Second Phase. The same assessment for health facilities isolated by the First Phase was covered in the Health and Segregation I study published in January 2004. It was deemed important to examine the existing capacity of these primary health clinics and their ability to maintain service coverage in their communities when the construction of the Wall is complete. Analysing the existing health infrastructure, programmes and services

provided in these communities will permit better planning for the health sector, especially when areas isolated by the First Phase have already experienced obstacles in accessing health care.

Following its completion, the Second Phase has already isolated or is likely to isolate 32 primary health care clinics. The Jerusalem and Bethlehem districts have been particularly badly affected. Eighteen isolated clinics are located in Jerusalem, 6 in Bethlehem, 3 in Salfit, 4 in Ramallah and 1 in Qalqiliya. As indicated in Graph 4, Seventeen of these clinics are governmental, while 13 are managed by NGOs and 2 by UNRWA.

Graph 4: Number and percentage of the Wall's Second Phases isolated clinics by district



1.1. Health infrastructure

Sanitary facilities and electricity

Sanitary facilities for clinics isolated in the Second Phase are generally adequate with 90% (29 clinics) having toilets in average, good or excellent condition, 97% (31 clinics) have sinks and 97% (31 clinics) have running water. Ninety seven percent (31 clinics) have electricity, but power is generally available only during working hours, at most 6 to 8 hours a day. Inter alia, this limits the clinics' ability to maintain the cold chain system for vaccination services. The sanitary facilities of clinics isolated in the north by the First Phase are more vulnerable, as 15.4% of these clinics have no running water and 7.7% have no sinks.

Laboratory services

The provision of laboratory services is relatively uncommon among clinics in rural areas of the West Bank. Further restrictions in access to such services caused by the Wall therefore pose a major problem for affected communities and health workers. In general, rural West Bank clinics are classified into two main groups on the basis of the type of laboratory diagnostic tests they can perform:

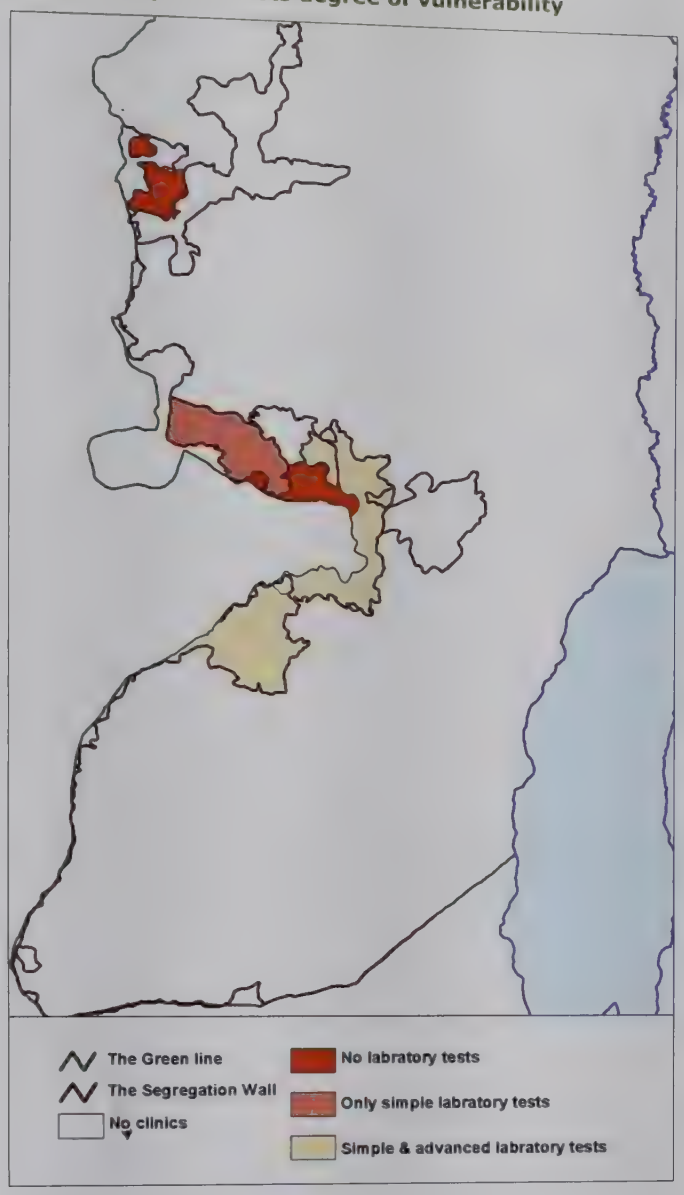
- Clinics offering basic tests not requiring the presence of qualified technicians including blood glucose tests, hematocrit and urine analysis tests, using simple kits.

- Clinics that have the capacity to perform more advanced laboratory tests such as biochemistry tests, cultures, and other tests requiring the availability of specialized equipment and trained laboratory technicians.

Providing basic lab tests for patients that will be completely cut off from any other facilities in the West Bank is becoming increasingly crucial. In this regard it is very important to note that only 10 of the 32 isolated clinics (31%) provide basic lab tests not requiring the presence of qualified technicians.

This situation will render three enclaves with primary health care clinics vulnerable as they will be unable to provide any types of lab tests and will be isolated from other health structure in the West Bank who can perform these tests. As shown in Map 17, these enclaves are: 9, 10 and 17. Although clinics in villages west of Ramallah in cluster 15 have laboratories, they can only provide simple lab tests and will certainly be in need of specialized services as they will be totally isolated from both the cities of Ramallah and Jerusalem.

Map (17): Lab tests degree of vulnerability



Moreover, only five clinics (enclaves 18, 19, 20 and 24) provide advanced lab tests requiring the availability of specialized equipment and trained laboratory technicians. These clinics are located in Jerusalem and Bethlehem districts but cannot serve their own rural hinterland outside their enclaves, including other parts of their governorate.

This also means that in addition to communities stranded outside the Wall, the regional rural population inside the Wall is denied regular access to advanced laboratory tests.

The availability of laboratory services is therefore an issue that concerns all health providers in areas affected by the Wall because the quality of clinical laboratory testing involves several factors, including the availability of local technicians, adequate selection of tests by clinicians, the quality of equipment and reagents, regular quality control, adequate reporting systems and clinicians ability to read results. Almost all of the above elements are lacking in the 32 isolated clinics, while local health needs are ever growing.

Pharmacies and drug procurement

The availability of pharmacies is good at 72%. However, 9 clinics have no pharmacies; Clusters that are expected to encounter serious problems where clinics have no pharmacies include the Jerusalem district villages of Rafat, Deir Ballut, and Az Sawiya in cluster 10, Beit Duqqu, At Tira and Kharbatha Al Misbah in cluster 15, and 'Anata in cluster 20. Cluster 10 will be mostly affected in terms of drug provision since none of its clinics have pharmacies. However, these clinics are located in clusters where other nearby clinics are able to provide medication.

Due to closures and the concentration of West Bank supply, delivery and distribution systems in Ramallah, all isolated clinics are likely to face supply problems and will therefore need to accumulate larger stocks, this process has already started in some clinics. Another mechanism adopted by local governmental and NGO health providers to ensure drug supplies to rural clinics isolated by the Wall includes organizing convoys with international health organizations, such as the WHO, UNICEF and the ICRC.

1.2. Programmes and services

Preventive health care services

The report assessed six types of preventive and promotive health services provided in clinics that will be isolated in the Second Phase: pre-natal care, post-natal care, well-baby clinics, vaccinations, health education and screening programmes. The system of barriers is creating significant gaps

in preventive service provision and is impacting the quality of preventive services. Table 2 shows the number of clinics offering each type of preventive services.

Table 2: Number of isolated clinics in Phase 2 offering preventive services by enclave

Enclave number	9	10	15	17	18	19	20	24	Total
Total # of clinics in each enclave	1	3	11	1	2	6	2	6	32
Pre-natal	0	1	6	0	1	3	1	1	13
Post-natal	1	3	10	1	2	2	2	3	24
Well baby	1	0	8	1	1	4	2	5	22
Vaccination	1	3	8	1	2	3	2	4	24
Health education	1	3	8	1	2	3	2	4	24
Screening	0	0	5	1	2	3	2	1	14

As the table above indicates, enclaves 9, 10 and 17 are in most need of more developed preventive services.

A final area of concern is the quality of preventive services in these affected areas. As the preliminary proxy indicator of quality, the report assessed the availability of speculums and sonic aids in clinics offering pre-natal care. Although the presence of basic diagnostic instruments in clinics does not in itself reflect the quality of pre-natal care services provided by them, the lack of such instruments would reflect a significant structural shortage, severely limiting the physicians ability to undertake proper diagnosis. Further quality assessments are clearly warranted.

Availability of Well Baby clinics

At 69% (22 clinics), the availability of well baby clinics is relatively high in the isolated clusters. Of the 10 clinics with no well baby services, nine are located in enclaves where other clinics are able to provide these services. In enclave number 10, however, none of the three clinics offer well baby services, thus rendering it vulnerable in this respect.

Family planning services

It is generally assumed that the provision of maternal and child health care services, by offering couples family planning and counselling services, impacts fertility behaviour and reduces infant and female mortality. However, only a small share of health service facilities in the West Bank provide family planning assistance. In addition, the majority of health care resources are found in urban areas and in the centre of the West Bank, leaving very patchy coverage in the northern and southern regions as well as in isolated areas. Thirty eight percent (12 clinics) of the isolated clinics do not provide any family planning services. Enclaves number 9 and 17 with around 3,400 inhabitants have no access to such services. Furthermore, the comprehensiveness of services varies widely: Only 22% (7 clinics) of the identified clinics provide pills and IUDs with 9% (3 clinics) providing consultations, along with pills and IUDs.

The provision of family planning services should therefore be a priority for health service providers, particularly in areas isolated by the Second Phase.

Speciality services

According to WHO standards, rural clinics rarely offer speciality services as they can be accessed in urban centres not far away.[28] However, the path of the Wall along with the various networks of barriers, checkpoints, gates and earth mounds have separated urban areas from rural areas and hence sharply curtailed access to speciality services. Sixty nine percent (22 clinics) of isolated clinics provide no speciality services. Enclaves number 9, 10, 17, 18 and 24 are the most vulnerable since their inhabitants of the seam zone have no access to physiotherapy, ophthalmology, gynaecology, paediatric, or dermatology services. Around 144 diabetes patients cannot be treated inside these enclaves and instead they have to seek care outside, crossing gates to nearby rural clinics and cities.

Service quality: availability of essential diagnostic and patient management instruments

Assessing quality of care remains one of the most problematic aspects of any analysis of health care systems, especially in Palestine. The last three years of separation of the different areas within the West Bank have deprived the health sector of the possibility to adopt protocols and standards in the different aspects of service provision to ensure quality. This poses a major challenge in developing an integrated health system as further

[28] Palestinian Ministry of Health, Health National Plan, 1996

fragmentation of West Bank health care facilities are compounded by the construction of the Wall.

Given the time and data limitation of this survey, the processes and outcomes of health care delivery in areas affected by the Second Phase could not be thoroughly investigated. This report only analyses the availability of basic patient management and diagnostic instruments in clinics isolated by the Second Phase, taking this as a proxy indicator for potential quality problems in curative services rendered to patients.

A small but significant number of clinics lack basic patient management and diagnostic instruments resulting in serious quality issues. Forty seven percent (15 clinics) of clinics lack stretchers; 16% (5 clinics) lack oxygen bottles; 31% (10 clinics) lack sonic aids and 31% (10 clinics) lack IV lines. Enclave 9 is worst off as none of its clinics have stretchers, oxygen bottles, sonic aid or IV lines as shown in Table 3 below:

Table 3:Availability of essential diagnostic and patient management instruments

Lack of instruments	Enclave number with none of these instruments
Ostoscope	**19**
Ophthalmoscope	**19**
Stretcher	**9**,10,**17**,20
Oxygen	**9**,**17**
Sonic Aid	**9**
IV lines	**9**,**17**

These enclaves are the most vulnerable with clinics lacking basic diagnostic instruments, hence severely limiting their ability to provide proper diagnosis. This points to serious shortcomings warranting further evaluation and assessment in the future.

Vaccination programmes

Twenty five percent (8 clinics) of clinics do not provide vaccination services: 9.4% (3 clinics) in cluster 15, 9.4% (3 clinics) in cluster 19 and 6.2% (2 clinics) in cluster 24. Vaccinations are mainly available through governmental clinics serving isolated communities as the Ministry of Health is considered the main provider for vaccination services.

However, although vaccination services in all isolated governmental clinics are available, it is envisaged that the delays in delivery of the vaccination from the centre to these clinics will be a major problem, especially when medical teams are continuously being prevented from accessing these closed areas.[29] This situation will increase the risk of preventable disease such as Hepatitis B, Measles, Polio, Tetanus and Diptheria.[30]

Staff availability and training

The isolated clinics are generally open to the public from morning until early afternoon, for an average of seven working hours a day, six days a week. However, for much of this time the clinics are not in a position to provide "appropriate" health care of sufficient quality, because physicians are frequently absent. Due to access problems, doctors are typically present in the clinics for an average of only 6 hours per day, 4 days a week. For the remainder of their opening hours, the clinics are thus mainly managed by health workers. This limited availability of physicians is clearly incommensurate with the growing health needs of the population, a discrepancy that is only increasing due to the Wall's construction.

The limited availability of physicians living in the same villages as the clinic operates, in comparison to health workers, is due to the fact that doctors generally live in villages or cities in other districts, whereas nurses and health workers tend, on the whole, to live in the same village as the facility in which they work, or in nearby communities.

Seventy eight percent (25 clinics) of doctors live in nearby villages within the same district, from which 18.8% (6 clinics) come from the same village as the clinic operates. Fifteen point six percent (5 clinics) come from a nearby city in the same district, while 12.5% (4 clinics) come from far away cities and villages, compared to the 75% (24 clinics) of nurses or health workers who live in nearby villages in the same district, of which 43.8% (14 clinics) come from the same village in which the clinic in question is located. 15.6% (5 clinics) come from far away cities and villages.

What these numbers illustrate is the disproportionate importance of health workers and nurses in the management of clinics serving isolated communities. In the face of more pervasive closure and isolation health workers are becoming increasingly important for the continuity and resilience of local health care provision.Despite this, 69% (22 clinics) of clinics provide no continuous education to their staff; clinics in enclaves 9, 17 and 18 are particularly lacking such programmes.

[29] Refer to Section One of access denial incidents of medical teams and patients.
[30] These are the main vaccinations included in the regular schedule delivered by the Ministry of Health

Nurses and health workers should be supported with programmes that enhance and upgrade their skills and capacities through continuous training in order that they can be most effective.

2. Degree of vulnerability along the Wall's First and Second Phases

In HDIP's "Health and Segregation I" study, an analysis of health services available to communities isolated by the First Phase was conducted. The study also included recommendations from community workshops in Jenin, Tulkarem, Qalqiliya and Ramallah, as well as interviews with the main health care providers.

In an attempt to uncover any changes occurring within the health sector in areas isolated by the First and Second Phases throughout the last year, obstacles faced by the isolated health care facilities were tracked. Two years after the construction of the Wall, clinics still face similar problems as few changes have emerged. These problems can be summarised as follows:

Access of medical teams to their workplace: Medical teams constantly face difficulties in reaching their workplace. However, when asked about strategies to overcome access problems for instance, initiating a change in place of residence for medical staff, only the three governmental clinics of Deir Ballut, Rafat and Az Zawiya in the district of Salfit (Enclave 10) did employ such a change. Instead of residing outside the enclave, doctors and nurses working in Deir Ballut and Rafat clinics now live in nearby villages within the same enclave. Moreover, the nurse working in Az Zawiya clinic (Enclave 10) now lives in Az Zawiya village.

Finding health professionals residing either in, or nearby the same village that the clinic operates in, within the same cluster is extremely problematic. In fact, the Ministry of Health has highlighted the issue it faces in finding health experts who reside in the same village or city as their workplace. Usually, a doctor works in several clinics located in different districts.[31]

In order to combat some of these problems, 4 clinics have extended their doctor's working hours by an average of 60 minutes. These are: PMRS Biddu clinic (Enclave 15), Deir Ballut, and Rafat governmental clinics (Enclave 10) and HCC Habla clinic (Enclave 6). The number of staff has not, on the other hand, increased.

[31] Discussion with the Ministry of Health in Qalqiliya

Where medical staff live has only become an issue since the Wall's construction. The separation of communities compels health professionals to leave their homes earlier than usual as they have to travel through different barriers, including checkpoints and gates. In fact, 63% of clinics (25 clinics) reported a delay in medical staff arriving at their workplace.

Patients access to health centres: Thirty-six percent of clinics (13 clinics) noticed that a proportion of "old" beneficiaries had stopped coming to their clinics potentially because of their inability to travel through gates and checkpoints. On the other hand, 53% (19 clinics) reported that "new beneficiaries" from nearby areas are visiting these clinics as they are unable to access their old health centres.

Difficulties in drug procurement: Fifty-five percent of clinics (22 clinics) still face difficulties in drug procurement, especially for chronic disease patients. To solve this problem, health care providers have adopted different strategies; some clinics refer to international organizations to procure medication inside the enclaves, others try increasing the supply of drugs in their clinics for a period of 3 months in an attempt to overcome the problem of lack of medication.

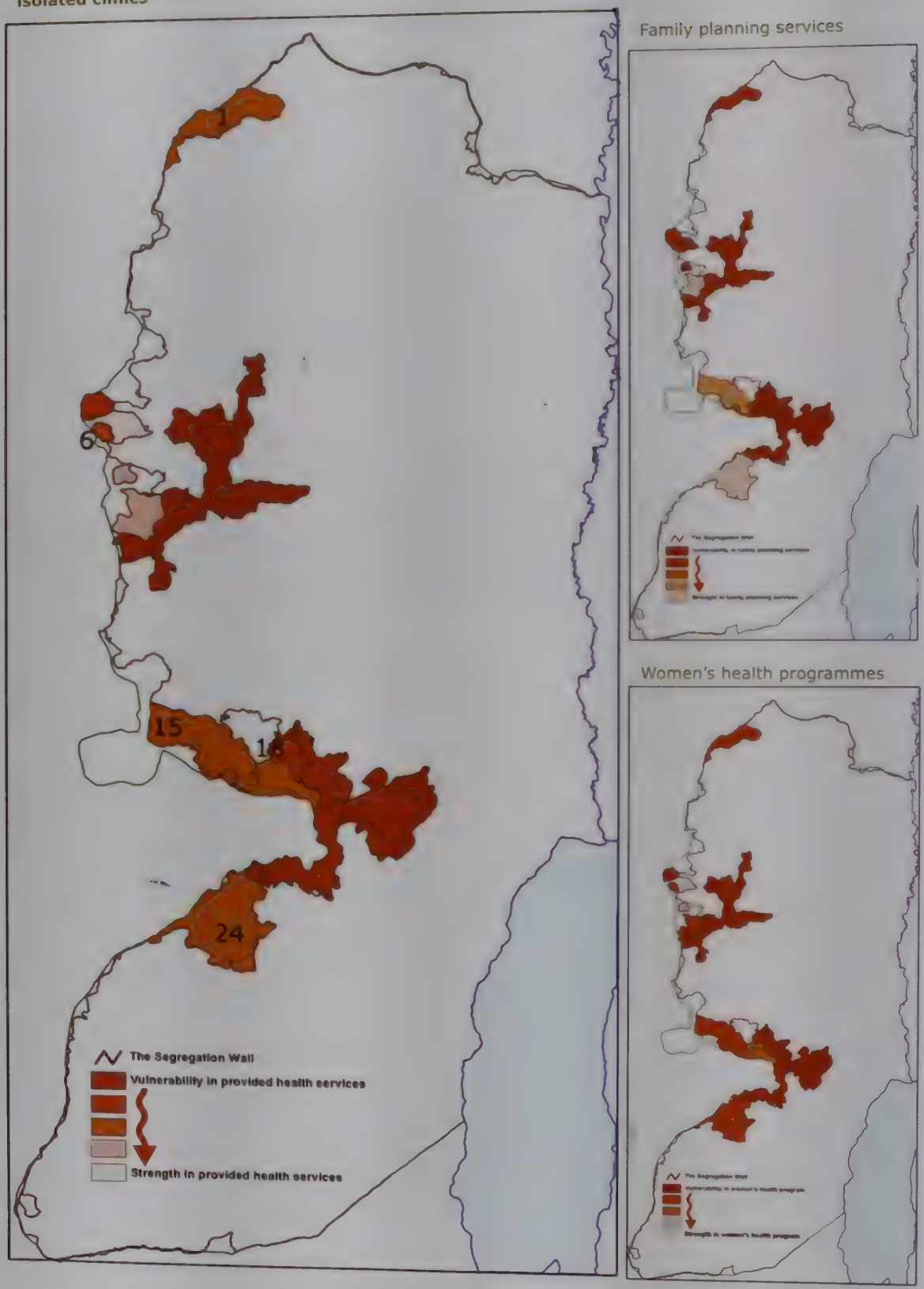
Viability and effectiveness of clinic programmes and services: Responses from questionnaires indicate that most programmes were affected, especially those involving home visits, vaccination and school health in nearby villages. Most affected were the mother and child health programmes. Some medical equipment for instance, biochemistry tests and cultures need maintenance material that can sometimes be difficult to get, thus affecting the quality of tests, as well as their availability to patients in some clinics.

By considering these findings and the analysis of heath services existing in all isolated communities, the most vulnerable population clusters formed were identified below. This vulnerability mapping used the availability of family planning services, child health services, women's health programmes, speciality clinics, laboratory facilities and diagnostic instruments as their indicators. Levels of clinics (Map 19) and population (Map 20) within each enclave were then integrated into the analysis to detect the different degrees of vulnerability. Health care providers should concentrate their actions in the following regions and speciality areas as indicated by the series of maps number 18:[32]

- Cluster 1 Barta, Jenin, mainly in all areas.
- Cluster 6 Habla, Qalqiliya, mainly enhancing women's health programmes, provision of drugs, preventive services, speciality clinics and laboratory services.
- Cluster 9 Azoun 'Atma, Qalqiliya, mainly enhancing women's health programmes, provision of drugs, preventive services, speciality clinics, family planning, diagnostic instruments and laboratory services.
- Cluster 15 Latroun Area, Ramallah, enhancing women's health programmes and laboratory services. Upgrading the level of the PHC clinic in Beit 'Anan to be the main health focal point for all nearby villages within this cluster.
- Cluster 17 Beit Iksa Area, Ramallah, enhancing women's health programmes, provision of drugs, preventive services, speciality clinics, family planning, diagnostic instruments and laboratory services.
- Cluster 18 Bir Nabala Area, Jerusalem, enhancing speciality services and family planning programmes.
- Cluster 24 Bethlehem area, Bethlehem, enhancing family planning programmes, speciality clinics and women's health programmes.

[32] Refer to Annex 3 for detailed information about population and health infrastructure and programmes in each cluster

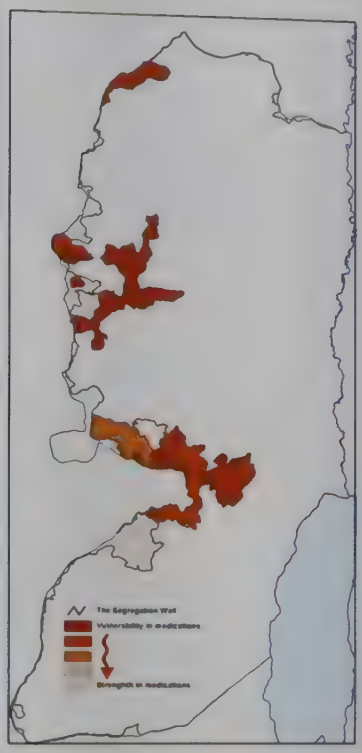
Map (18): Degree of vulnerability: Overall capacities of isolated clinics



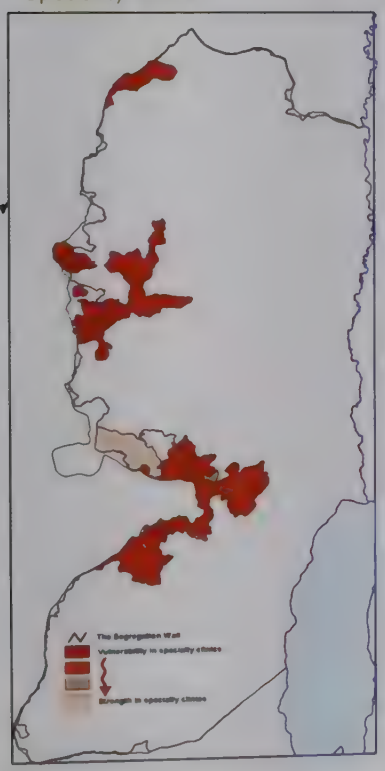
Child health care services

Laboratory tests

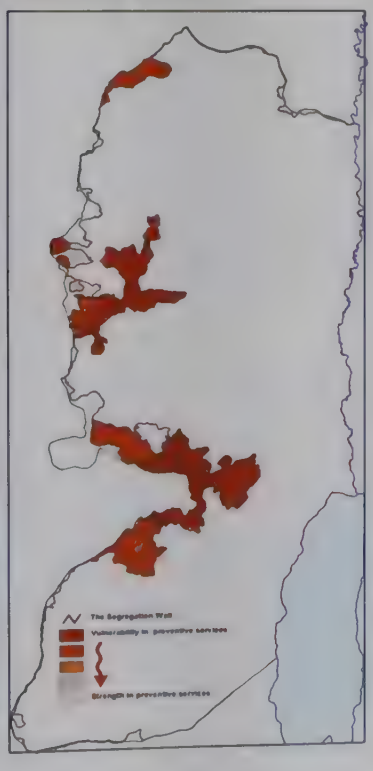
Medication



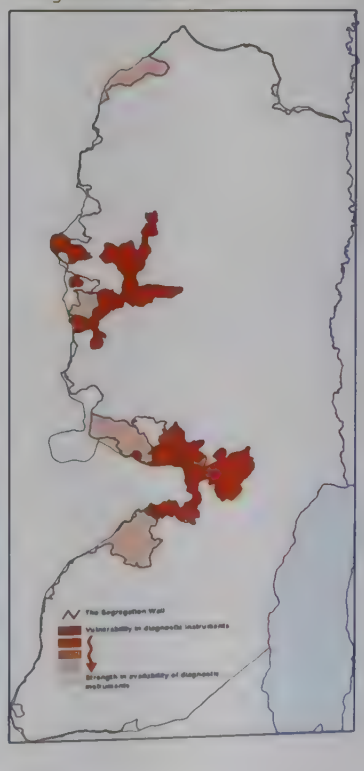
Speciality clinics



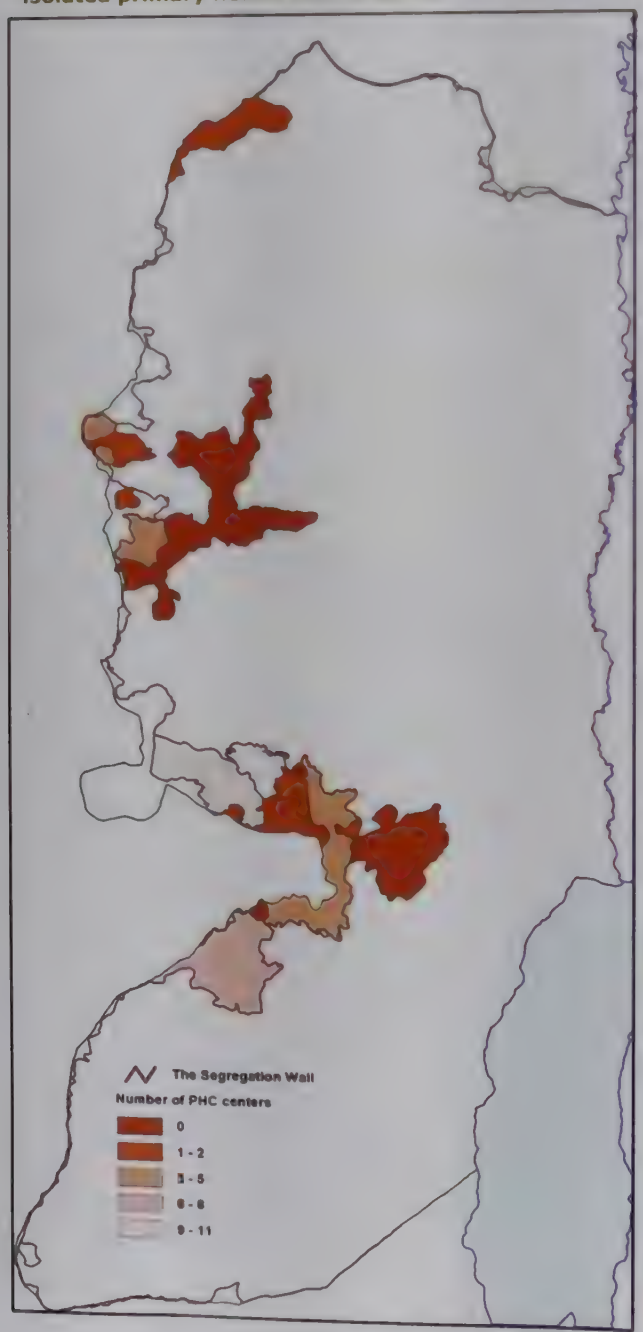
Preventive services



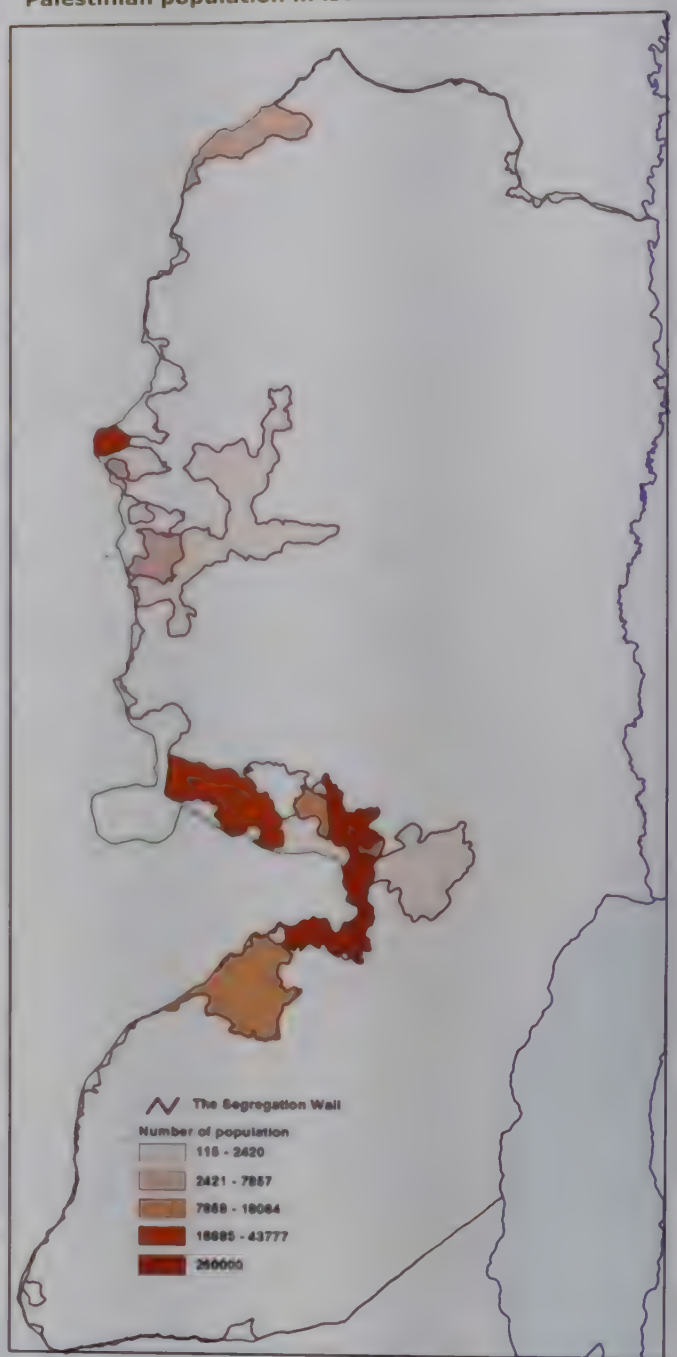
Diagnostic instruments



Map (19): Degree of vulnerability: Distribution of isolated primary health care centres



Map (20): Degree of vulnerability: Distribution of Palestinian population in isolated clusters



Section Three

Access to Tertiary Care & Rehabilitation Services

1. Specialized health care in East Jerusalem

1.1. Hospitals in East Jerusalem

For years Jerusalem has been the centre for secondary and tertiary medical services, not only for the residents of Jerusalem but for all Palestinians in the West Bank and the Gaza Strip through a system of referral. In 2005, there were eight hospitals with around 580 beds approved by the Palestinian Ministry of Health.[33]

Table 4: Hospitals in East Jerusalem

Hospital Name	Specialization	Hospital Type
Al Maqassed Hospital	Specialized	Charitable
Dajani Hospital	Maternity	Private
Jerusalem Maternity Hospital	Maternity	Private
Jerusalem PRCS Hospital	Maternity	NGO
Saint Joseph Hospital	Specialized	Charitable
Princess Basma Centre for Disabled Children	Rehabilitation	NGO
Augusta Victoria Hospital	Specialized	NGO
St John's Ophthalmic Hospital	Ophthalmology	Charitable

Al Maqassed hospital is considered, for example, as the main hospital in Jerusalem that provides heart care treatment, whereas the Augusta Victoria provides kidney dialysis for patients in East Jerusalem and the West Bank. Moreover, Saint John's Eye hospital is the only ophthalmic hospital for Palestinians and the only training site providing ophthalmic training for local nurses and doctors. On the other hand, in the field of rehabilitation, the Jerusalem Princess Basma Centre for Disabled is a unique resource and a national referral centre for Palestinian disabled children.[34]

1.2. The separation of Jerusalem

Jerusalem has, effectively, been separated from the rest of the West Bank and Gaza since 1996 as Palestinian patients holding of Palestinian green IDs have been refused entry for treatment, except for those with a special permit issued by the Israeli government.[35]

Since the beginning of the Intifada in 2000, the isolation of Jerusalem has been intensified and hospitals have suffered financial problems due to the decrease in patient occupancy rate due to diminishing referrals from the West Bank and Gaza Strip. Before 2000, about 90% of patients of the major East Jerusalem hospitals came from the West Bank and the Gaza Strip. In 1993, occupancy rate for Al Maqassed hospital reached 110%, whereas now it is less than 50%. St. John's hospital faces a similar situation as it has experienced a 75% decline in patients and a dramatic drop to only one ambulance per day from Gaza carrying perhaps one or two patients as emergency cases.[36] Since the Intifada, Dajani Hospital has been risking closure as fewer patients are being able to reach it. With the construction of the Wall, the hospital's situation has become more and more critical.

Moreover, hospitals face other grave difficulties in maintaining their staff as 75% of the staff of the four major hospitals of East Jerusalem come from outside the city. Special permits requested by and obtained from the Israeli government, are needed for medical staff residing in the West Bank. However, some medical personnel are refused permits.

According to Dr. Al Hasson Hassan, Director of Al Maqassed Hospital, the hospitals have reduced its Palestinian staff from the West Bank as permits to enter Jerusalem are being difficult to obtain. The number of staff working in these hospitals has been decreasing over the years, especially with the intensifying closure policies that have affected Jerusalem since 2000. As Table 5 from HDIP's database shows, throughout the period 2000-2002, the number of staff for the Jerusalem Maternity and Al Maqassed hospitals has dropped. The availability of funds and support for other hospitals have made it possible to counter the problems of staff shortage, such as in the case of Saint Joseph's and PRCS hospitals.

[33] HDIP Hospitals Database 2002, http://www.fejh.org, PCBS: Jerusalem 1999: Statistical Year Book No. 2, MOH 2002, annual report
[34] Asma Imam and Dr. Izzat Ayoub, Review of Health, www.multi-sector.org/review/health.
[35] Mustafa Barghouti and Jean Lennock, Health in Palestine: Potential and Challenges, Palestine Economic Policy Research Institute (MAS), March 1997, p 48
[36] Robert Brooks, Rami Nasrallah and Rassem Khamaisi, The Wall of annexation and expansion: its impact on Jerusalem Area, The International Peace and Cooperation Centre, p. 84

Table 5: The change in the total number of staff for the period 2000-2002

Hospital Name in Jerusalem	2000	2001	2002
Al Maqassed Hospital	612	550	510
Dajani Hospital	32	33	35
Jerusalem PRCS Hospital	120	120	120
Saint Joseph Hospital	85	95	105
Jerusalem Maternity Hospital	45	45	32

Utilising a permit policy for patients and hospital staff to access Jerusalem, pressure is exerted on Palestinian institutions to reduce the number of Palestinians from the West Bank in Jerusalem. Obtaining permits for medical reasons is already a long process, one which will only become more extended with the advent of the Wall.

1.3. Carving Jerusalem area into separate clusters

A new type of isolation will occur when the "Jerusalem Envelope" is complete as not only Palestinians from the West Bank will be unable to access secondary and tertiary services in Jerusalem, but also Jerusalemites residing outside the J1 borders will be denied health services only provided in East Jerusalem. They depend on the East Jerusalem health care system including primary, secondary and tertiary health care services and, furthermore, pay health insurance premiums as members of the Israeli Health Insurance system.[37] Currently, there is no clear procedure as to what will happen to these people, two potential scenarios are they might have to wait for permissions to be allowed into hospitals or might be obliged to go to West Bank hospitals where they are not insured and will have to bear higher costs.

This new isolation due to the path of the Wall will create six enclaves within the Jerusalem area (see Map 21):

Cluster 18 Bir Nabala Area

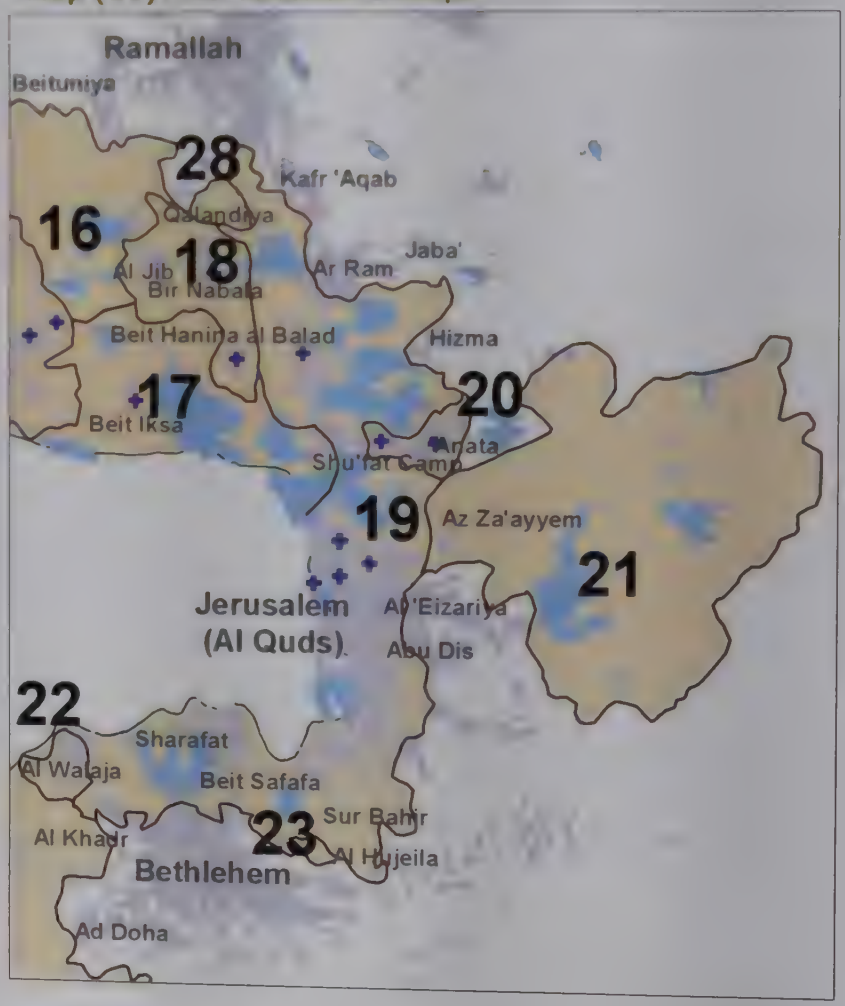
The four villages of Al Judeira, Al Jib, Bir Nabala and Beit Hanina Al Balad with a total population of 14,012 will be isolated in an enclave with no access to health care services. Unable to sustain its operations due to the closure measures, the only clinic that was managed by Al Maqassed charitable organization was closed in 2003.

Cluster 20 Shu'fat and Anata area

The exclusion of Shu'fat Refugee Camp and Anata from East Jerusalem will impact 13,500 Palestinians which is considered as the second largest Palestinian neighbourhood in East Jerusalem after the Old City of Jerusalem. As holders of Jerusalem ID cards, they are mainly dependent on health centres in East Jerusalem. The isolation of the refugee camp from basic services found at the urban hub will endanger its sustainability.

There are no hospitals in Shu'fat Refugee Camp, no emergency clinics or services. The closest emergency

Map (21): The "Jerusalem Envelope"



[37] Asma Imam and Dr. Izzat Ayoub, Review of Health, www.multi-sector.org/review/health

services are in Wadi El Jos, which is located on the other side of the Wall. There is only one UNRWA clinic that has a dentist and one general physician. Eighty percent of its residents go to clinics outside the camp in East Jerusalem. Another primary health care clinic managed by the MoH is located in Anata.

Moreover, many of the disabled people living in the camp will be particularly affected since an average of 20% will need to go through the Wall in order to maintain their rehabilitation activities, thus placing an additional burden on the disabled individuals and their families.

Cluster 21 Az Za'ayyem village

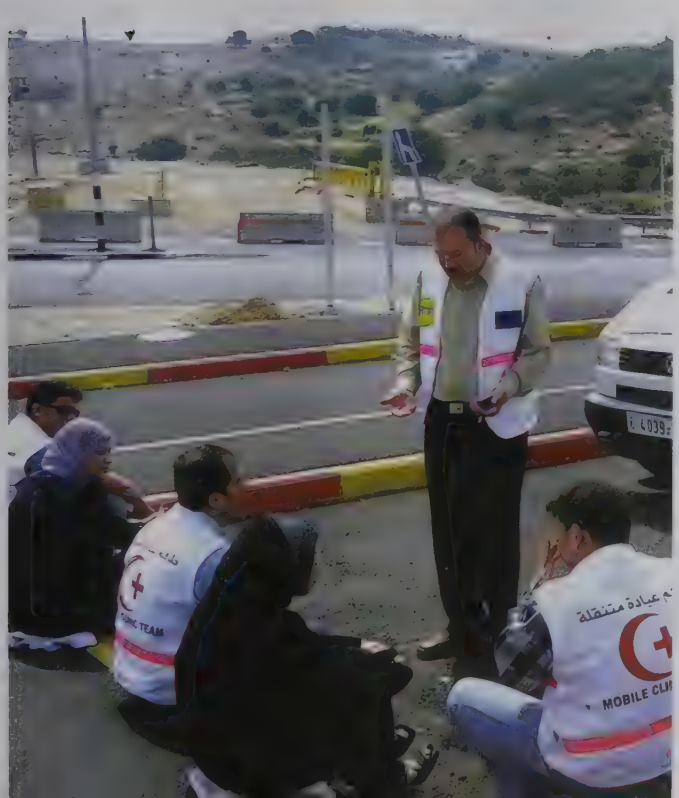
Az Za'ayyem village will be included with Malee Adumim settlement but completely separated from East Jerusalem as well as other communities in the West Bank. Its 2,420 residents will have no access to health care services at all.

Cluster 28 Qalandiya village Area

The 1,135 inhabitants of Qalandiya village will be isolated in a small enclave with no health care services.

Ar Ram area

Although Ar Ram will not be enclosed in a separate cluster, its 25,187 inhabitants who are totally dependent on hospitals and other health services in Jerusalem will also no longer be able to access the city. Many of them have Jerusalem IDs. There are also no hospitals in Ar Ram, no ambulance service and no emergency clinic. There are merely four clinics that offer basic medical services; which are used by neighbouring villages as well.



2. Rehabilitation services and the impact of the Wall on disabled individuals

Chronic disease patients, elderly people, pregnant women, children and disabled individuals are among the most vulnerable groups jeopardized by the ongoing construction of the Wall. In this report, we focus on the impact the Wall has on disabled individuals and their access to rehabilitation services, due to a lack of existing information on this issue, specifically on the increased vulnerability of disabled people due to the Wall. The Wall's impact on other vulnerable groups could, unfortunately, not be examined due to the limited time and resources available.

2.1. Overview of rehabilitation services and disability in Palestine

According to the World Health Organization (WHO), people with special needs are those with health-related restrictions or who lack the ability to perform an activity.

In the 1997 census, the Palestinian Central Bureau of Statistics (PCBS) revealed that the rate of disabled Palestinians totals 1.8% including 1.9% in the West Bank and 1.6% in the Gaza Strip. The districts of Qalqiliya and Tulkarem had the highest percentage of disabilities in the West Bank at 2.3%, followed by Tubas district at 2.1%. Jerusalem, Ramallah and Al-Bireh, Jericho, and Hebron were found to have the same percentage at 1.7%. The highest prevalence of disability was found among Palestinian refugees (1.9%), and the lowest prevalence amongst urban residents (1.7%).[38] While these rates are already alarming, civil society organizations estimate a higher rate at 2-3%, or an estimated 65,000 disabled Palestinians in the West Bank and Gaza Strip.[39]

The Palestinian rehabilitation system in the West Bank and Gaza Strip is divided into three main levels: primary care which covers 60% - 70% of rehabilitation; secondary care level which covers around 20% - 30%; and tertiary care with specialized services which should cover 10% of the needs according to Community-Based Rehabilitation (CBR) principles.[40] CBR promotes the equal opportunities

[38] PCBS, Population Report, Palestinian Territory - First part (Final Results), May 1999.
[39] Interview with Mr. Ziad Amr, Chairman of the Palestinian Union for the Disabled, March 2005
[40] PCBS & ministry of social affairs, Survey of Rehabilitation Services at the Intermediate Level In the West Bank and Gaza Strip, 1997

and social integration of all people with disabilities. It is implemented through the combined efforts of disabled people themselves, and their families and communities, integrating appropriate health, education, vocational and social services.[41]

Primary services include outreach programmes (mobile services) and CBR mainly provided to communities by health organizations. Recent studies illustrate that under the leadership of the Central National Committee for Rehabilitation, a non-governmental body that acts as an umbrella for all the non-governmental organizations working towards the care of the disabled, the CBR programme network covers 240 localities with basic rehabilitation services, serving approximately 50% of the disabled population.[42]

The secondary level offers intermediate services. There are around 114 such governmental and non-governmental institutions in the West Bank (62) and Gaza Strip (52) that provide services to disabled persons. Thirteen of these institutions are under the supervision of governmental organizations. There is an urban-rural bias in the provision of secondary-level services, with most institutions being concentrated in cities.[43]

Tertiary care is available at medical centres with facilities that offer sophisticated and specialized rehabilitation services for the disabled, and that are considered an important part of the national rehabilitation sector. Although there are only three specialized centres, in Ramallah, Jerusalem and Bethlehem (See Map 22), they cover a large part of the disabled Palestinian population between them. CBR programmes and specialized rehabilitation centres serve as excellent rehabilitation programs as models and concepts.

Although there are a number of rehabilitation institutions in Palestine, they still face a number of challenges:

- Specialized centres with capacity to provide sophisticated and high quality rehabilitation services are few and limited due to their geographic location. Geographic location of rehabilitation services is in fact not consistent with disability distribution in the West Bank, since most cases of disabilities are in the North of the West Bank whereas institutions are centralized in the middle.[44]
- Existing centres are poorly equipped and their current logistical capacity is insufficient to fulfil the needs of disabled persons in their localities;
- Costs of rehabilitation services are high;
- There is a severe shortage of specialized professional staff;

Map (22): Rehabilitation centres in the West Bank

[41] ILO, UNESCO, UNICEF and WHO. Community Based Rehabilitation (CBR) for and with people with disabilities. 2002.
[42] Giacaman, R. A Community of Citizens.: disability rehabilitation in the Palestinian transition to statehood. 2001.
[43] PCBS & ministry of social affairs, Survey of Rehabilitation Services at the Intermediate Level in.the West Bank and Gaza Strip, 1997
[44] PCBS, Persons with Special Needs, 2002

- Cramped locations, and the inability of these institutions to provide outdoor activities for disabled persons act as a major hindering factor to the development of rehabilitation services[45]; and

- Specialized care and rehabilitation services are perceived to be weak and insufficient to fulfil the needs of the disabled within the context of movement restrictions and segregation.

2.2. The impact of the Wall on the health and socio-economic situation of the disabled

Most disabled people experience poor socio-economic circumstances, as more than 50% live below the poverty line. Equally, many are deprived of the benefits of the Disabled Persons Card[46] and health insurance rights mandatory under the Palestinian Rights of Disabled Persons Law.[47] Furthermore, disability limits access to education and employment, which leads to further economic and social exclusion. Poor people with disabilities are caught in this vicious cycle of poverty and disability, with each being both a cause and a consequence of the other.

The Wall has affected health and rehabilitation services, the socio-economic condition, and the relationship of disabled individuals with their families. As a result of their already restricted mobility and need for unique specialized care, the suffering of disabled people has been heightened as continuous health care is crucial for their well being.

The fact that all of the specialized rehabilitation services are available outside the Wall, usually in cities in the heart of the West Bank, leaves disabled people with very limited options for health care and rehabilitation. The level of services available in isolated villages is extremely limited. Access to outside rehabilitation centres was difficult even before the construction of the Wall and now, along with checkpoints, access to specialized services is becoming almost impossible for individuals with disabilities.

In addition, the psycho-social conditions of disabled persons have been influenced by the Wall, since people with special needs face a number of social and economic obstacles that prevent their full participation in everyday life. Groups most badly affected include the mothers of disabled children, as the burden of care that they bear limits them from engaging in the public sphere to a significant extent.[48] In addition, as interaction outside the Wall is very limited, people with special needs tend to spend long hours at home. Difficulties in accessing public and social services like education, or employment opportunities have also increased. As access to economic centres, usually cities, is curtailed by the Wall, the economic situation of disabled people becomes increasingly difficult. This leads to a deterioration in their physical and mental health, as they can no longer afford specialized medical care or essential medication. As such, the quality and quantity of health care also falls into question.

In communities within the Jenin, Qalqiliya, Ramallah and Tulkarem districts, some health providers offered basic services such as mobile clinics, and the training of health workers, and some secondary services to counter the difficulties people face reaching hospitals. Disabled individuals are covered mainly by CBR programmes. However, medical staff in most cases were prevented from reaching rural areas. Complications such as kidney failure were caused by late arrival to proper care facilities. The health status of the population is also affected negatively for people that require daily medication or physiotherapy.[49] Moreover, the referral of patients to secondary health services and outreach programmes in isolated clusters is limited to a handful of organizations such as PFS, PMRS, PRCS and UNRWA.

The greater availability of CBR programmes could lessen access problems for the disabled and cushion the consequences of their isolation due to the Wall. However, problems remain in that CBR professionals face related problems in accessing these isolated areas.

2.3. The impact of the Wall on rehabilitation programmes, continuity of service provision and financial sustainability of specialized centres

The limited number and centralization of specialized centres in the West Bank is not a problem within the framework of a geographically connected area. In fact, the inability of disabled individuals to reach these centres due to the Wall, checkpoints and other barriers has only contributed to the increased workload of these centres as they have to rely more on outreach programmes. The only specialized centres available are the Khalil Abu Raya Rehabilitation Centre in Ramallah, the Jerusalem Centre for Disabled Children, and the Bethlehem Arab Society for Rehabilitation (BASR) in Beit Jala.

Difficulties are encountered in performing outreach programmes in areas around the Wall. Institutions face:

[45] Palestinian Independent Commission for Citizens Rights, Medical Preparedness to Rehabilitate those Disabled by the Intifada, 2001
[46] General Union of Palestinian Disabled People. The Disabled Rights Law, Number 4, 1999 (In Arabic)
[47] Palestinian Independent Commission for Citizens Rights, Medical Preparedness to Rehabilitate those Disabled by the Intifada, 2001
[48] Interview with Mr. Ziad Amr, Chairman of the Palestinian Union for the Disabled, March 2005
[49] Interview with Dr. Allam Jarrar, PMRS in February 2005.

- Financial problems;
- Access problems due to the Wall and checkpoints;
- An overload of work inside and outside rehabilitation centres, particularly in CBR programmes;
- A lack of equipment, medication and/or expertise;
- A lack of cooperation between similar organizations; and
- An overall change in the development plans of each organization.[50]

In an extremely difficult climate, and as a result of the Wall and other barriers, difficulty in accessibility makes it impossible to reach the disabled in some cases. As such, outreach programmes are not able to reach areas behind the Wall in order to provide medication or rehabilitation services.

Although outreach programmes are part of the solution, the above issues make it almost impossible to expand existing programmes geographically, and for a long duration. In terms of ophthalmology for example, the BASR centre sends outreach groups to areas in Hebron and Ramallah. The capacity of such a programme is limited because of the lack of extra staff, as these programmes require occupational therapy, hearing aid specialists and doctors. Equally, as available staff at the centres are already struggling to cope with heavy workloads, outreach programmes, which draw staff away from the centres, are becoming more and more difficult.

Another issue facing specialized centres is the increase in admission rates. Disabled people from areas isolated and affected by the Wall are obliged to remain at the centres longer until their treatment is finished, as it is virtually impossible for them to travel back and forth. Thus, the number of days patients spend in the centre has increased and admission durations have increased by up to 130% in some centres.[51]

Current CBR teams are not adequately qualified to deal with special rehabilitation cases. The quality of CBR programmes has decreased over the last four years, as the nature and level of work has become more demanding since the construction of the Wall, while the level of qualification has remained the same.

Furthermore, treatment fees have also increased. While many cases would normally be out-patients, the difficulty in accessing health facilities means that patients often end up staying in the centre even when their health status does not require admission. Additionally, the referral agreement sometimes only covers rehabilitation whereas the patient might require other kinds of treatment. Such cases, along with cases where the amount of time and fees needed for treatment are underestimated, are frequent in the referral of patients.

Obliged to operate under difficult circumstances and with limited financial and human resources, service providers are trying to manage services as well as they can. They cannot release patients back before finishing their course of medication is completed, as this would lead to a deterioration in their medical situation. As such, health institutions are faced with a major dilemma.

This dilemma has negatively impacted the quality of service provided. Efficiency has decreased, as the cost of the same services has increased and money is no longer spent on the most important or urgent concerns. Although the cost of rehabilitation services is reasonable, most people cannot afford to pay for the entire treatment duration, which results in further complications for the disabled in many cases.

An alarming trend highlighted by focus discussion groups was that of specialized service providers experiencing great deficits in their budgets. The Ministry of Health on occasion delays patients referral papers, meaning that individual centres cover the costs of treatment, so that the Ministry is unfortunately indebted to these rehabilitation centres. Centres have been known to cover the costs of medication for those injured during the Intifada, without always receiving compensation from the Palestinian National Authority (PNA).

In an attempt to overcome some of the problems that specialized centres face, the main rehabilitation providers in the centre of the West Bank are working in cooperation with the smaller clinics in the North or South, where the follow-up of treatment is taking place. Specialists from the area where follow-up is required do so on an individual, case-by-case basis. These coordination efforts are not always successful however, and occasionally create additional problems. Some organizations work randomly in the field and channel their funds into medical equipment regardless of the actual needs of the people. In addition, funding opportunities do not always take account of the local needs of rehabilitation service providers.

One of the main changes that has taken place since the construction of the Wall is the diversification of

[50] Focus group organized by HDIP for rehabilitation service providers, March 2005.
[51] Palestinian Independent Commission for Citizens Rights, Medical Preparedness to Rehabilitate those Disabled by the Intifada, 2001

services provided by specialized centres. The three main specialized rehabilitation hospitals in the West Bank for example have expanded into different fields such as emergency and general health as opposed to concentrating solely on rehabilitation, in order to cope with the changing reality brought about by the construction of the Wall. Whereas patients used to seek treatment at specialized centres or hospitals in Jerusalem, with the Wall and other forms of movement restrictions, they now have to rely on existing West Bank rehabilitation centres, which are beginning to act as hospitals serving the surrounding areas (Hebron, Bethlehem Governorate, Ramallah, and occasionally, Nablus).

As a coping strategy, rehabilitation centres train families in caring for and facilitating the rehabilitation of their disabled family members. The training starts from the day the patient is admitted to the centre, to the day he/she is discharged. This training includes rehabilitation and clinical aid. Although this requires extra effort on the part of the centre, it usually helps in preventing complications after the patient is discharged, thereby in theory decreasing future admission rates and duration of stay.

Section Four

Response of Health Care Providers

1. Resisting collapse: Increased donor support

Efforts to build long-term capacity within the health sector have been undermined by the overwhelming need to meet the short-term, emergency situation. As such, health institutions are operating under "crisis management" in isolated areas, particularly as access to these areas becomes increasingly difficult, such as the cases of Barta'a Ash Sharqiya in enclave 1 in Jenin, Habla in enclave 6, and Azzoun 'Atma in enclave 9 in Qalqiliya.

This focus on emergency relief, a result of the "new, geography" of the West Bank, has shifted attention away from the long-term goal of developing and improving the health sector. Instead, health sector development initiatives have reverted once more to relief, disrupting years of work in building up an essential drug list and a rational drug use programme. In addition, the debate over how to finance government health services, such as introducing user fees or establishing national health policies and coordination mechanisms between health care providers, has also come to a standstill. Existing coordination structures focus mainly on emergency relief activities. In response to the national emergency, all health care providers have understandably begun to provide emergency services in isolated areas, such as the provision of mobile clinics for a certain period of time, the duration of which is restricted by the availability of funding. These initiatives have not followed a unified national strategy, simply because the MoH has thus far failed to provide or help develop such a plan.

Since the construction of the Wall, there have been many predictions of collapse of isolated health facilities. However, despite access problems the ability to maintain service provision through the public and NGO sectors has been admirable.

Increased donor support has been one of the main factors responsible for this ability to cope, helping to cushion the effect of the humanitarian needs created by the Wall and contributing to the continued provision of services and relief activities. A second factor relates to the cohesiveness of the fabric of Palestinian society, which has been crucial in absorbing persistent pressure and repression, characterised by increasing unemployment, declining incomes and growing poverty. A third factor concerns the effort, perseverance and dedication exhibited by workers in the health sector, NGOs and civil society

institutions, who have striven to preserve the continuity of services and activities under critical conditions.

2. General coping strategies: Actions of health care providers in affected areas

Service provision has become more difficult than ever due to the restricted access of service providers to their worksites and beneficiaries to service provision centres, especially in isolated clusters. While access to primary health care facilities has been restricted in some enclaves, access to secondary and tertiary health care facilities in East Jerusalem and Ramallah is becoming harder as well. Ambulances have also been subjected to searching and delays, or even denial of passage. In many cases, mobile clinics teams have been denied access through gates and checkpoints.

Nevertheless, service provision has mostly been preserved thanks to the emergence of decentralized policy and flexibility in handling emergency situations. Those concerned with health care conditions in Palestine view the health sector as one of the best examples of cooperation between the public sector, NGOs, international organizations and donors in managing the crisis, especially as regards coping with the isolation of communities, clinics, hospitals and prevention of access for patients and medical teams.

Measures have been adopted by primary and secondary health care providers to overcome problems related to prevention of access to health services caused by the system of barriers, although there is no unified national plan adopted by all health care providers.[52] Some of these measures include:

[52] This information is the outcome of interviews, meetings and focus groups organized with all health care providers in districts affected by the Wall in the West Bank

In primary health care

- **The creation of new primary health care centres:** New health centres have been created to serve communities that have been isolated from other health facilities due to the Wall and other barriers. For example, a new governmental primary health care clinic in Adaba (cluster 5), south of Qalqiliya, was established in 2004 to serve the communities of Ad Daba and Ras Tireh.[53]

- **Decentralization of health activities:** Due to access problems, the Ministry of Health and NGOs adopted a more decentralized approach in implementing their daily medical activities. For example, Dr. Ziad Al Safouti, MoH Qalqiliya Director indicated that instead of centralizing Qalqiliya (a city surrounded completely by the Wall) for medical activities, the nearby village of Azoun, outside the Wall, had became the centre for drug distribution to rural areas in the district. Medical teams working in rural clinics now meet in Azoun every day before going to other villages.[54]

- **Cooperation with international and Israeli organizations:** Cooperation between national and international organizations, such as UNICEF, WHO, and ICRC, or Israeli organizations like Physicians for Human Rights, has increased around Wall affected areas in order to facilitate drug distribution to rural clinics when Palestinian medical teams are denied access by Israeli soldiers.

- **Extension of working hours in NGO clinics:** Some NGO clinics in affected areas have extended their working hours. For the past nine months, the Health Care Committee (HCC) clinic in Azoun has been open from 8:00 am to 11:00 pm with two shifts of doctors with different specialities.[55]

- **Expansion of existing primary health care clinics:** Some NGOs have upgraded the level of their primary health care centres to become mini-emergency hospitals covering a wider geographical area.

- **Introducing new mobile clinics:** The number of mobile clinics working in the area of the Wall has considerably increased. Within the framework of an ECHO and Medico International funded project, PMRS now operates mobile clinics in 4 affected areas. PRCS concentrates its activities mainly in Qalqiliya villages, while UHCC focus on villages in Bethlehem (See next section for further details).

- **Emergency phone line:** The PRCS has set up emergency phone line services to assist the population in isolated areas in cases of minor health concerns and emergencies, especially at night.[56]

- **Increase of ambulance use:** The use of ambulances to take patients to clinics and hospitals has increased.

- **Training of medical staff and communities members:** Some training courses of health professionals organized by NGOs have been implemented. Trained staff was then provided with medical equipment and kits to facilitate their work. Other trainings were organized for 300 women and midwives in isolated villages.

- **Centralized emergency centres:** In cooperation with WHO, some health care providers are selecting centralized sites to assist pregnant women and establish 24-hour emergency centres.

In secondary health care

- Increasing the number of technical staff and administrators in government hospitals, especially in the north of the West Bank.

- Setting up new specialized units in hospitals.

- Expanding existing hospitals.

[53] Dr. Ziad Al Safouti, MoH Qalqiliya Director, District Health Emergency Coordination Meeting (HECM), Qalqilya Primary Health Care Directorate, Qaqliliya city, 27 October 2004
[54] Ibid.
[55] Yaseen Ramadan, HCC, District Health Emergency Coordination Meeting (HECM), Qalqiliya Primary Health Care Directorate, Qaqliliya city, 27 October 2004.
[56] Abd Al Rahim Abu Saleh PRCS, District Health Emergency Coordination Meeting (HECM), Qalqiilya Primary Health Care Directorate, Qaqliliya city, 27 October 2004

- Using ambulances to transport patients from villages to hospitals.

All these measures are individual initiatives of health care providers in reaction to the existing situation. They are neither based on a concerted Palestine-wide plan nor on strategies of a national scale.

3. Special actions: Mobile clinic activities in isolated areas

In response to access problems encountered by medical teams and patients due to the construction of the Wall, health care providers have begun running mobile clinics to serve affected communities. In this section, we will provide a comprehensive overview of these activities especially in the Wall area.

Information collection was laborious, especially when mobile clinics service provision, quality and policies vary from one provider to another. Thus it was a challenge to analyse this data as one comprehensive unit.

It was problematic, for example, to assess the effective range of mobile clinics as the number of villages visited varies from one provider to another. For the purpose of this study, the number of currently running mobile clinics here refers to the number of villages visited irresepective of the frequency of visits to these villages throughout the year 2004-2005. This is because not all health care providers have fixed schedules of visits for a determined number of villages per month. For example, according to the information obtained from UNRWA during the year 2004 - 2005, some villages were only visited twice per year, yet for the purpose of this study, they will still be counted as one mobile clinic operating in the village.

Distribution of mobile clinics

From a total of 312 mobile clinic activities reported to HDIP, the main provider was PMRS with 129 mobile clinics in affected areas. However, this number is scheduled to decrease dramatically, as in early July 2005 funding is only assured until September 2005.

UNRWA (98 mobile clinics) and PRCS (23 mobile clinics) are the second and third most important providers for mobile clinics in the Wall area.

Table 6 below shows the number of villages covered by mobile clinics in the Wall area.

Table 6: Number of villages covered by mobile clinics in the Wall area by district

Number of Organization	Jenin	Tulkarem	Qalqiliya	Salfit	Ramallah	Jerusalem	Bethlehem	Hebron
MoH		1	20				16	1
PMRS	21	19	20	20	17	1	11	20
PRCS		3	8				1	14
UNRWA	2			2	47	11	12	24
HCC			4					
HWC	1						2	1
PFC	18	1						

The largest number of villages covered by mobile clinics in the entire West Bank (not only around the Wall area) are found in Ramallah and Hebron districts (see Map 23 and Map 24).[57] The main reason for this extensive presence is the large number of rural villages far away from urban centres in these districts. Moreover, both the Ramallah and Hebron districts are among the largest and most populated in the West Bank. The second highest number of mobile clinics is found in the district of Jenin, followed by Bethlehem and Qalqiliya.

When assessing models for mobile clinics, this high concentration of mobile clinic activities should be analysed in a very cautious way taking into consideration the following issues:

First: Due to their temporary character, the period for which these mobile clinics operate differs from one provider to another. Funding is not consistent and operations usually extend over a period of 6 to 12 months. Some mobile clinics might cease operating in communities or might reduce their number of visits due to restricted funding. Hence this high number of mobile clinics should not be taken as an indicator by itself but rather taken into consideration along with other factors.

Second: Medical services differ from one mobile clinic to another. For example, although PMRS has the highest percentage of mobile clinics, its clinics provide various specialized services in a sometimes very limited geographical area. Services include care for women and chronic disease patients and those needing physiotherapy. Therefore analysis should focus not only on the number of mobile clinics by provider but also on the kind of services provided by geographical area.

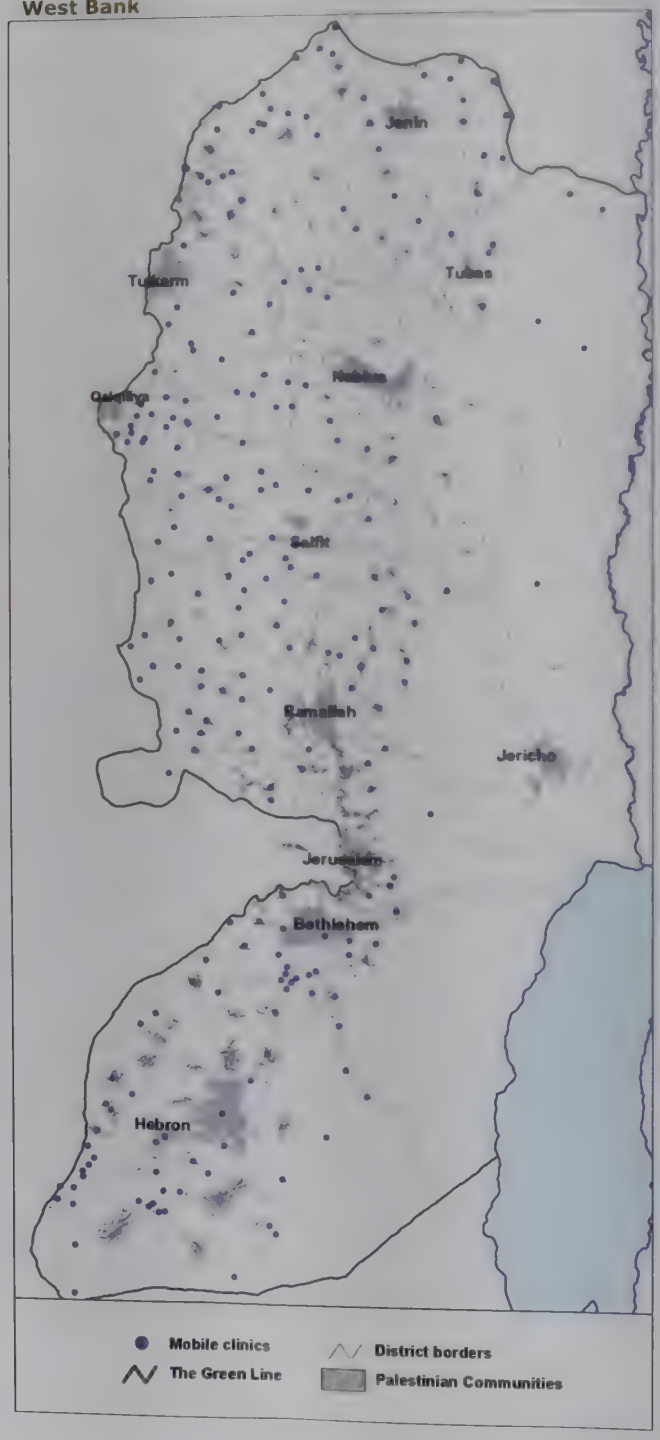
[57] It should be noted here that data about other areas in the West Bank, such as the availability of mobile clinics in Jericho, was missing. This report was mostly concerned with the mobile clinics within the Wall area. Hence, data was refined to include mobile clinics that operate in a radius of 1 km within the Wall area

Third: Schedules of visits to communities are sometimes constant and consistent and at other times are not defined, varying according to the internal policies are of the organization. UNRWA, for example, organizes visits to around 100 villages in the West Bank, yet some communities are visited only once or twice per year. This contributes to the inflated number of mobile clinics for some health organizations in the West Bank as when a mobile

Affected communities served

To assess mobile clinic activities around the Wall area, communities within a radius of 1 km to the Wall area were included in the analysis. Maps 25 and 26 show that 131 mobile clinics serve communities in 1 km radius of the Wall area (see Map 27 for combined distribution of mobile clinics and the 100 primary health care centres around the Wall).

Map (23): Distribution of mobile clinic visits in the West Bank



Map (24): Distribution of mobile clinic visits in the West Bank

Moreover, Map 20 shows that the largest presence of mobile clinics within the Wall area is in the Qalqiliya district. This high concentration of mobile clinics has been in operation since 2004 and is justified because the Wall is already built south of Qalqiliya city, causing communities in 8 separate enclaves (3,4,5,6,7,8,9,10) to be isolated with minimum health infrastructure and total separation from secondary and tertiary health care services. As the Second Phase is being built in Ramallah and Bethlehem, it is expected that the number of mobile clinics will proportionately increase in the central and southern West Bank.

Provision of medical services

Ninety six percent of mobile clinics provide basic treatment and drug distribution to patients with 60% providing health education and first aid courses. Fifty-nine percent of mobile clinics have laboratory tests available. The majority of mobile clinics consist of 2 health workers, a doctor and a lab technician or a nurse and a doctor.

Only 15% of mobile clinics provide specialized services, such as screening for disability cases, rehabilitation, physiotherapy, obstetric care and treatment for patients with chronic afflictions. PMRS, PRCS and HCC provide more specialized services. PMRS run a specialized mobile clinic for women's health and chronic disease patients, and both the PRCS and UHW provide physiotherapy. Only 6% of mobile clinics provide vaccination services all of which belong to the Patients Friends Society of Jenin.[58]

Average stay in communities

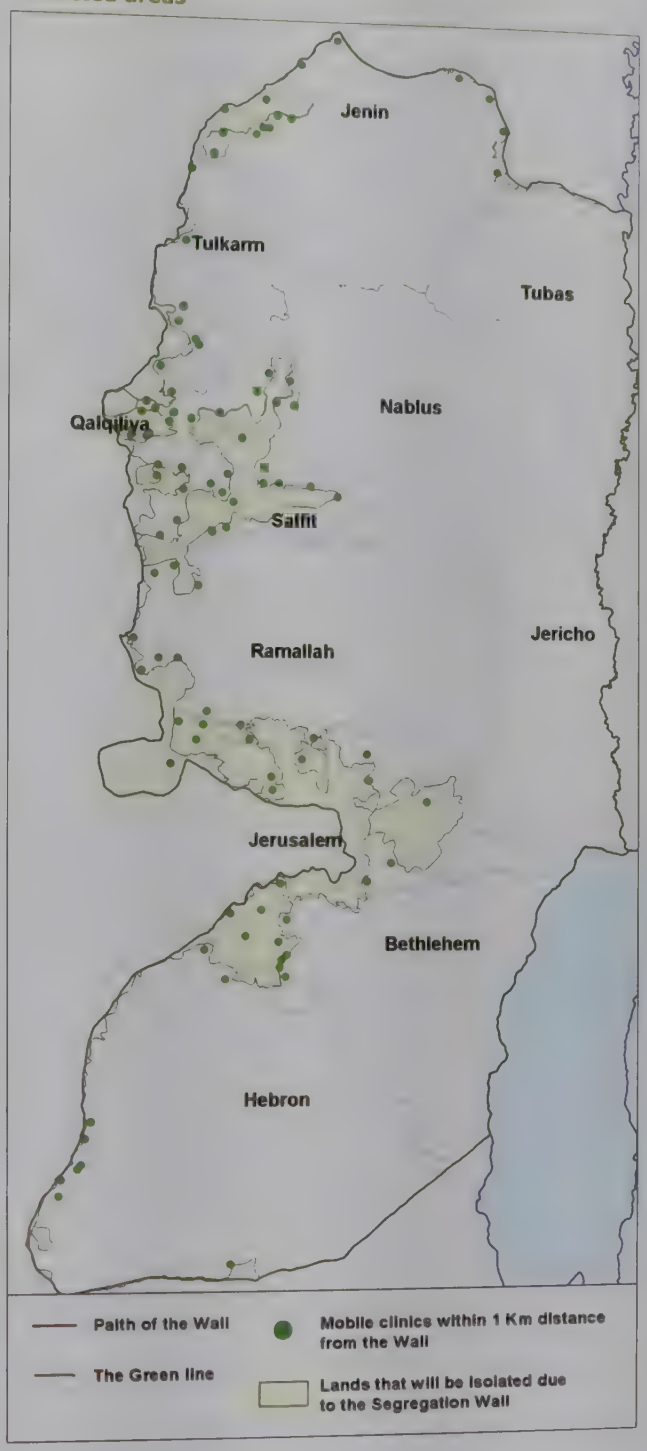
Mobile clinics operate an average of 5 hours per day per village with some delays in difficult areas like Barta'a Ash Sharqiya (enclave 1). These delays inevitably influence the quality of services delivered.

Schedules and duplication of services

It was difficult in some cases to obtain accurate schedules for all health care providers running mobile clinics. Most health care providers have constant schedules with the exception of UNRWA, whose schedule contains no apparent policy for choosing which villages to visit. This creates a major dilemma for avoiding duplication and ensuring integrated high quality services.

The operation of several mobile clinics in one area: Out of the 131 villages visited by mobile clinics between November 2004 and April 2005, there were 27 cases where several health providers visited the same site but at different times. Health care providers do coordinate their daily activities in villages to ensure a greater coverage of health services for populations that have no available clinics and are isolated by the Wall. And although coordination measures exist among health providers, they need to be intensified. By the end of each month, some NGOs, for example,

Map (25): Distribution of mobile clinic visits in affected areas

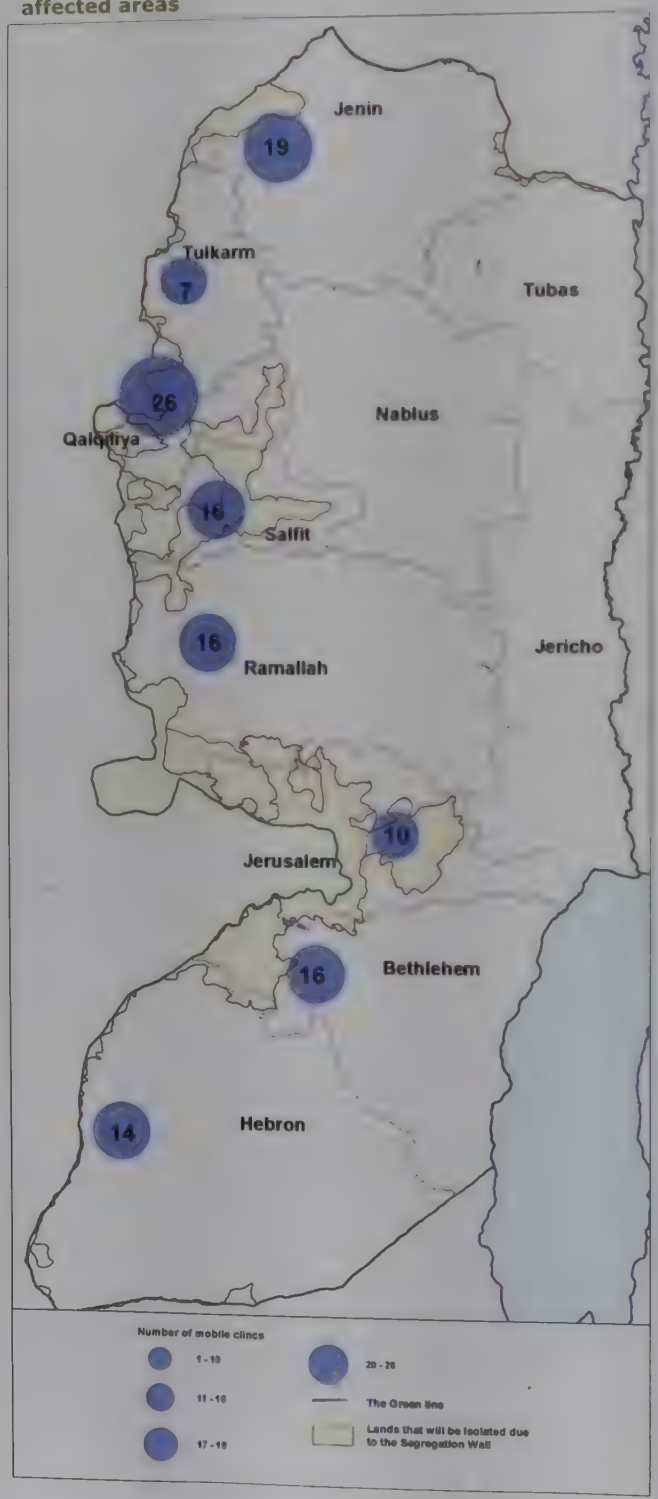


[58] The Ministry of Health provide vaccinations in their normal clinics as well as to rural communities without governmental health centres

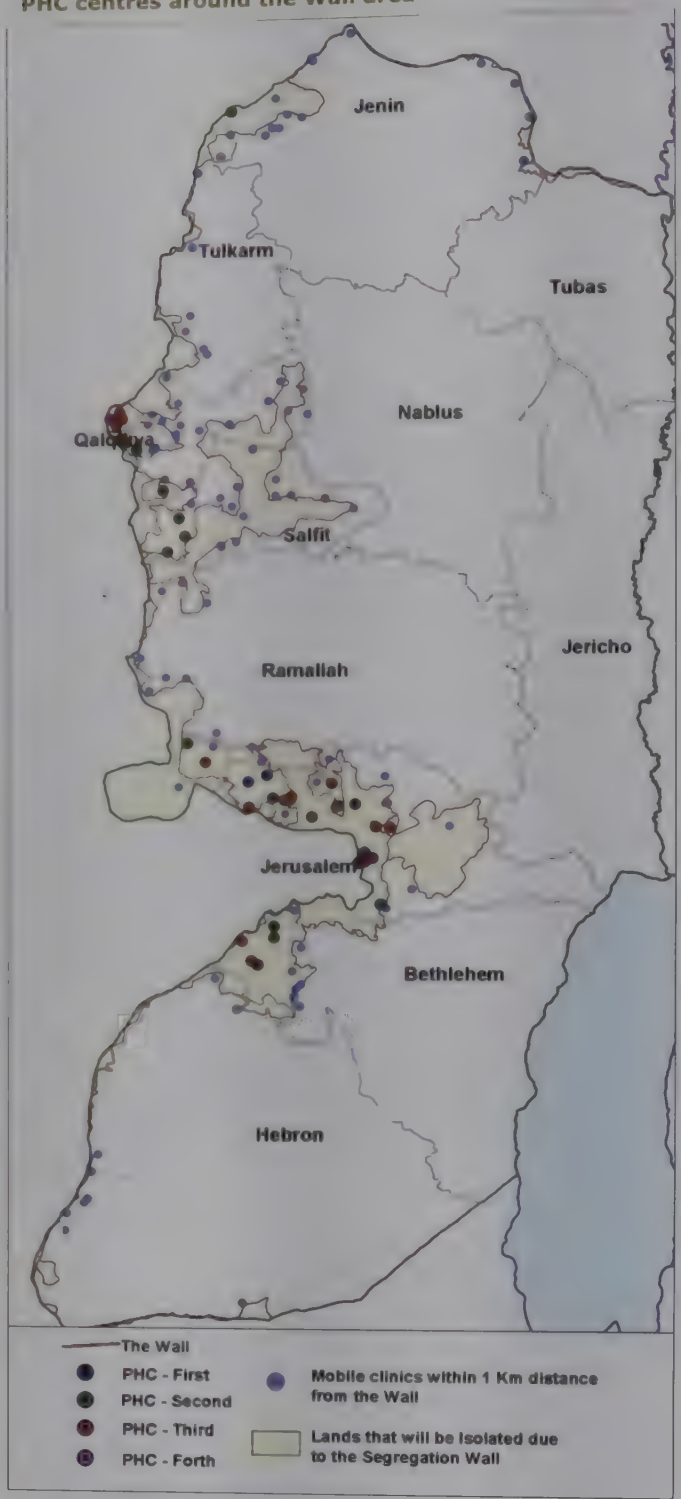
PMRS regularly send their schedules for the coming month to the Health Inforum, Ministry of Health and other NGOs.

In order to improve coordination, HDIP, in cooperation with the Ministry of Health and supported by Medico International, took the initiative and called for a national meeting on 19 May 2005. It was agreed to set unified schedules for all mobile clinics operating in the West Bank. HDIP will take the lead to ensure this coordination in the future by disseminating any available information on the issue. Within this framework, the first mobile clinic coordination meeting was organized with the main health care providers and in cooperation with the MoH and the Health Inforum.

Map (26): Distribution of mobile clinic visits in affected areas



Map (27): Distribution of mobile clinic visits and PHC centres around the Wall area



Experience shows that any duplication can be easily avoided by intensifying coordination among health care providers, especially regarding their mobile clinic activities in affected areas.

The operation of mobile clinics in communities served by primary health care centres

Of the 131 villages visited by mobile clinics between November 2004 and April 2005, 48 of the sites also have primary health care centres. Among these 48 sites, 8 are first-level clinics, 26 are second-level clinics and 14 sites are third-level clinics (For explanation of levels, see Annex 1).

This "geographical duplication" within the same villages should not be considered as "service duplication" when taking into consideration four important factors. First, the opening hours of some of these primary health centres are insufficient. Secondly, a doctor is sometimes not available in first-level clinics and only partially available in second-level clinics. Whereas the WHO, within the framework of the "Health for all campaign" considers a minimum of one permanently available general practitioner (plus PHC worker) per 5,000 inhabitants as a critical indicator, the reality of many Palestinian communities is an insufficient GP presence of as little as 4 hours per month. Many MoH clinics are open for only a few days per month, sometimes offering services only to specific groups like mothers with children (mother and child care) or children (vaccination), providing none or very reduced services to chronic disease patients, elderly people, disabled and men. These factors reduce practical cases of duplication to 14.

Third, mobile clinics cover uninsured people in communities having governmental centres as uninsured patients have to pay and can't afford the fees in most cases. During the past three years many who used to be covered by the Governmental Health Insurance (GHI) system have not been able to pay their GHI fees due to economic hardship and therefore dropped out of the GHI coverage. As a consequence, a significant portion of the Palestinian population is not covered by the GHI.[59] Hence additional services are needed in order to cover this group, even in locations where MoH services exist.

Fourth, mobile teams that reach remote and isolated areas add value to the basic PHC services provided. The quality of services provided by GHI clinics does not always meet the minimum quality standards. Medication is often not available in sufficient quantities, and in some cases is not available at all. Basic equipment for examination is also not always available. Mobile clinic visits try to integrate and combine other programmes implemented by health care providers, such as preventive care, health education, screening, first aid, etc. The flexibility of mobile clinics to change schedules and integrate specific services according to local needs is a considerable asset.

Moreover, within a project funded by ECHO through Medico International, PMRS has begun preparing unified patient cards to be distributed among all health care providers running mobile clinics in Palestine.

The various coordination efforts of the Health Inforum, NGOs, HDIP and Medico International reveal that coordination is possible and though time consuming will ultimately prove very beneficial.

[59] Palestinian Ministry of Health, Palestinian Health Information Centre, Health Insurance Report 2003, www.moh.gov.ps

4. Shortcomings and recommendations

The following problems, hindering the efficiency of available models of mobile clinics, were identified:

Inconsistency of visits to isolated communities

Schedules denoting villages targeted by mobile clinics are not consistent for some health care providers as they change constantly. Coordination meetings have improved this situation tremendously, and measures like district coordination and better planning, will be taken by health care providers to tackle this problem.

Uncertain continuity of mobile clinic activities on a long term basis due to limited funding

The temporary nature of mobile clinics makes it difficult for health care providers to sustain such activities. It is agreed that mobile clinics, especially when active during crisis situations and in the Wall area, should not be permanent. Nevertheless, funding should be more consistent so that efficient coordinated quality services can be provided, as long as the difficult conditions that make these measures necessary continue. Running mobile clinics within the current context of movement restriction is the most efficient temporary solution in terms of cost-effectiveness. Their integration should be complementary to other initiatives and health programmes aimed at developing the health sector or overcoming emerging problems.

Weak assessment of community health needs

Assessments of the health needs of communities visited by mobile clinics are not drafted on district or national levels, but instead are often driven by donor's strategies and the availability of resources. In order to reach a more integrated and sustainable, but also cost-efficient response to the immediate humanitarian needs, while not weakening the national health system, strategies integrating humanitarian and developmental needs should be defined on a national level. Therefore HDIP, in cooperation with the Ministry of Health, aims to create district coordination committees to assess health needs by district that will be reviewed on a national level, identifying policies, priorities and possible actions for communities, to be agreed upon by the Ministry of Health, NGOs and UNRWA.

Different policies adopted by health care providers regarding patient's fees

During the meeting organized by HDIP on 19 May 2005, health care providers agreed that mobile clinics should introduce adequate patient's fees to ensure community participation in such activities, as well as a certain level of financial sustainability. Exemption should, however, be introduced for hardship cases. UNRWA finds it difficult to apply such a policy because some refugees face such dire economic situations, and exemptions would have to be applied to a huge portion of beneficiaires. Another meeting will be held soon to discuss these issues thoroughly on a national level.

Large numbers of beneficiaries

Large numbers of beneficiaries are regularly treated during one mobile clinic visits in some locations. More frequent visits should be planned in these locations.

Limited number of hours spent

Limited number of hours spent in some villages due to access problems and delays on various barriers. Advocacy efforts should concentrate on minimizing the prevention of access and the delays of medical teams to ensure effective health services and promote respect for humanitarian law.

Lack of specialized mobile clinics

Some specialized mobile clinics exist, such as mobile clinics for physiotherapy, women's health, ophthalmic care and chronic disease patients.

Unique models of specialized mobile clinics

Innovative models of specialized clinics, run by some NGOs, exist in Palestine. These mobile clinic activities (15%) aim to provide qualified and specialized health services to the inhabitants of remote rural villages, targeted especially at women, disabled and chronic patients. They are supported by permanent medical team, qualified to provide the services of gynaecologist, midwife, physiotherapy and lab work. They provide services to women (especially those with at-risk pregnancies), to young and elderly people with diabetes and cardio-vascular diseases and to disabled individuals needing rehabilitation. General practitioners as well as specialists in diabetes, rehabilitation are available depending on the needs of this particular population.

However, these models are limited, both in time and regional coverage, due to insufficient funding. Currently around 47 sites are visited by specialized mobile clinics. More support as regards specialized clinics is certainly needed.

5. Coordination among mobile health care providers

Responses to special questionnaires issued to mobile clinic operators confirmed that they do coordinate their efforts in order to complement each others activities and reach the largest number of beneficiaries possible. The principal means of coordination is the sharing of daily, weekly and monthly visit schedules, in order to avoid duplication.

However, it seems that there is still a gap in coordination. Even though schedules are distributed among health care providers, more than one provider sometimes serves the same site. This duplication of services is due to the fact that some health care providers, such as UNRWA, which is obliged to serve all refugees in need, are faced with a dilemma of either applying a unified strategy to all its beneficiaries or working within an emergency situation. The present health care system is in need of a national policy regarding the use of mobile clinics in the context of a fragmented and weakened national health system along with a multiplicity of national and international governmental and non-governmental health care providers. Further coordination at both a district and national level is required.

Furthermore, respondents noted that three problems limited the effectiveness of such coordination: a lack of advanced coordination on a national scale, a lack of standardization in the selection of the targeted villages and distribution of medicines, and a lack of feedback and reporting from the involved institutions. One of the consequences of these problems was the duplication of service provision within certain areas, a problem that is usually solved on a case by case basis. Duplication generally occurs because general plans to target vulnerable areas are still absent. Instead, planning is achieved individually by each organization and is usually subject to funding opportunities available at the time.

Hence, there is no clear national strategy to set unified criteria for Palestinian mobile clinic models. Each organization has its own policy for managing its mobile clinics. Criteria for village selection, the number of villages covered, time spent in each village and days selected, services provided and quality of health care as well as fees and/or cost recovery systems vary from one organization to another.

Another dilemma is the long time it takes between identifying needs, planning and approval of funding. Due to the lack of coordination mechanisms between donors, similar projects might be funded in the same regions or the same beneficiaries targetted, while other needs might remain uncovered.

Section Five

General National Polices for the Development of the Health Sector

The system of barriers constructed by Israel is permanently hindering effective and efficient health care provision in the West Bank. It is severely limiting the access of half a million Palestinians to primary and secondary medical care and preventing nearly the entire population of the West Bank and Gaza - some 3.3 million people - guaranteed access to the tertiary care mainly found in East Jerusalem.

For local health care providers, this has implications beyond the effects on individual clinical capacity. It has caused systemic changes to the geographical distribution of health services and their relationships to local communities.

Meetings with health care providers and focus groups stressed that special attention should be dedicated to the following main issues:

1. Temporary and emergency measures

In the context of this shift towards a more mid and long-term developmental approach in the health sector, there are many urgent measures that should be implemented in order to uphold minimum standards of health care coverage in the most affected areas. These include upgrading the level of isolated clinics by providing more medical equipment and medications, while developing existing laboratories and pharmacies. Local health professionals should also be empowered through the training of health workers, nurses and midwives and strengthening of cooperation with local councils. The latter should help build a database of midwives, nurses, doctors and technicians who reside in isolated communities.

Maintaining mobile clinics with regular and guaranteed funding is also crucial. This includes more continuity, financial sustainability and enhancing of the quality of services provided. Interruption of mobile clinic activities weakens the possibility of long-term coordination that aims at reducing duplications. Moreover, specialized mobile clinics can be complementary to the work of existing health centres in isolated clusters.

Special attention should be devoted to the establishment of birth centres and the training of midwives and village health workers to oversee proper home deliveries compatible with MoH policies, inter alia by providing them with medical kits. This should complement increased first aid training and more specialised medical training extended to local volunteers. In the meantime, mobile clinics should be the most important alternative system for providing health care to communities which either lack or have no access to either specialized or other health services.

Health providers should concentrate on women's health, rehabilitation and chronic patient mobile clinics, while enhancing specific PHC services in vulnerable clusters to serve as focal points for the isolated population.

Isolated clinics continue to face innumerable problems as before. Several measures, such as the operation of mobile clinics, have been adopted; yet physical access still remains a huge obstacle to health care services. Hence, there is a need for lobbying efforts by health organizations to urgently focus on ensuring access of medical teams and patients.

Cooperation with international and Israeli medical organizations - such as the joint medical visits that are taking place with Physician for Human Rights and Palestinian health providers in isolated areas - should be encouraged and intensified. Such joint medical days or mobile clinic visits as well as the participation of internationals in these activities, according to experience, contribute to improve access, while representing an important tool in advocacy.

2. Transition from the "crisis management approach" to mid and long-term developmental policy

Health care providers agree that there is a need to change the "crisis management" approach they have adopted for the past five years. Focusing on the development and capacity building of the isolated areas is a priority in comparison to focusing on delivering day to day services on an emergency basis.

Needs assessment at district and national level

Needs assessments should be comprehensive in order to determine the needs of vulnerable groups. Medical service providers should investigate the available services and potential for development in isolated areas instead of implementing random policies and measures. Assessments should include surveys that specifically target vulnerable groups like the disabled and their families, chronic disease patients, pregnant women and children, health and rehabilitation providers in affected communities and specialized service providers. The outcomes should serve as a foundation for future plans targeting vulnerable groups.

Capacity building for medical staff and community members

Capacity building programmes should be organized for medical staff working in isolated and affected areas to enhance their skills and capacities to deal with vulnerable groups, especially the disabled. Training of community members in the fields of rehabilitation and "safe deliveries" should be organized. People specializing in these fields should be stationed in isolated communities. It is also crucial to consider the development of maternity homes.

Upgrading the level of health centres and increasing decentralization

Upgrading specialized health centres, which can act as focal points for communities isolated within clusters, is crucial at this stage. Specific focus should be given to rehabilitation infrastructure and women's health programmes. Decentralization of activities should be complementary to upgrading the level of health facilities, since the problem of centralization has been amplified by the system of barriers. Medication storage facilities and new clinics do not necessarily need to be sophisticated and have very advanced services. Instead, they can act as temporary facilities supported by local councils and communities.

As previously mentioned, the quality of services provided by PHC clinics does not always reach the minimum quality standards. Medications are often not available in sufficient quantities within the MoH facilities and in some cases are not available at all. Basic equipments for examination are not available. From a policy point of view, the first priority would be to strengthen these clinics and the MoH system, and the second would be to encourage compensating deficits through NGOs and international organizations. This could be achieved through encouraging more joint MoH and NGO clinics where staff, expenses and responsibilities can be shared between the government and NGOs.

Enhancing outreach programmes

Increasing outreach programmes would lessen the negative impact on vulnerable groups, especially disabled individuals and chronic disease patients. Special kits, medications and specialized health professionals should be part of mobile clinic activities.

3. Policy dialogue between Palestinian health service providers

Improving health services in isolated areas should be integrated with the development of the national health system as a whole. Enhancing cooperation and policy dialogue among health service providers could be a powerful tool to reduce the impact of the Wall on access to health care services and help ensure quality services. HDIP launched the first local coordination meeting. It produced the following recommendations that should help improve future planning for the Palestinian health system:

- Centralizing and channelling information about health activities through HDIP and the Health Inforum, in cooperation with the Ministry of Health Information System, as an effective coordination tool and as the main way to distribute details to other health care providers. This would entail drafting common activities among health care providers based on the actual developments on the ground and the needs of communities.

- Organizing a national meeting with the Minister of Health and leaders of different health care providers to launch a national planning initiative for the health sector.

- Regular meetings to ensure policy coordination via the Central Coordination Committee (CCC) - set up during the 19 May 2005 meeting - which will meet every two months.

- Formulation of District Coordination Committees (DCC) to take responsibility for organizing district coordination meetings during which health district needs and activities will be assessed according to the local needs and in cooperation with all health care providers. This will take into consideration the capacity of health facilities in the district, their levels, programmes provided, opening hours, medical teams available, and the presence of mobile clinics. The district committee will work on different measures to develop the health systems for a period of two years, potentially managed by more than one health care provider according to each one's speciality. These projects will then be presented to possible donors.

Meetings will be organized once a month and recommendations will be reported to the CCC. To achieve a more sustainable approach to the development of the health sector, existing national health infrastructure should be strengthened and complemented where necessary by informing donor strategies and joint activities to upgrade the health care provision under the current circumstances.

- Preparation of a unified patient record to be distributed to all patients served by mobile clinics.

This system will reduce the number of beneficiaries seeking unnecessary treatment. It will enhance systematic coordination between health care providers operating in the same area.

4. Linking national and donor policies

According to World Bank estimates, donors have provided about US $315 per inhabitant per year to the West Bank and Gaza since the beginning of the Intifada, which is an exceptional level of international commitment. However, even if donor disbursement had been doubled to US $2 billion in 2003 and 2004, the poverty rate would still, according to the World Bank's own calculations, only have been reduced by 7% by the end of 2004. This shows, that without a political solution of the conflict, sustainable development in the West Bank and Gaza can not be achieved, even under condition of considerable international aid.

Although donors have shown considerable interest in contributing to alleviate the humanitarian needs resulting from the construction of the system of barriers through the funding of emergency projects, these initiatives were often scattered and did not follow a general sector policy. This is also due to the fact, that strategies to face the humanitarian situation in the occupied Palestinian Territories are often following specific strategies of individual donors. In order to reach an integrated and more sustainable, but also cost-efficient, response to the immediate humanitarian needs, strategies integrating humanitarian and development needs have to be defined on a national level and shared with international donors. Care must be taken throughout this process to not weaken the national health system and the important work of its national institutions.

The cooperation that has been pioneered by HDIP with the Ministry of Health and all other concerned health care providers is an important step in this direction. The creation of District Coordination Committees to assess health needs by district should be further strengthened. Plans have also been made to share and analyse needs at a national level. Policies, priorities and possible actions for communities will be identified and agreed upon by the Ministry of Health, NGOs and UNRWA. Enhancing coordination among all health stakeholders will ensure that funding for the health sector will be distributed according to nationally concerted strategies, based on joint needs assessment and the experience of national organizations that have been operating in the West Bank and the Gaza Strip for years.

It is important to note that in seeking to mitigate the humanitarian impact of the Wall, the important role of Palestinian national and civil society organisations in developing a future sustainable health system should not be weakened, but strengthened.


64
65

Annex 1: Glossary of terms

Behind the Wall

The First and Second Phases of the Wall have created or will create 11 enclaves sandwiched in between the Wall and the Green Line, cut off from the rest of the West Bank.

Bypass roads

Roads for settlers use only enabling them to travel between settlements on the West Bank without having to pass through Palestinian communities. These bypass roads are prohibited for Palestinian use.

Complete Enclosure by the Wall

The First and Second Phases of the Wall have or will create 9 pockets of isolated Palestinian communities completely surrounded by the Wall.

Complete Enclosure by the Wall and other structures

These seven clusters will be surrounded by the Wall and settlement roads or "security routes" or "temporary paths". These structures are in all cases prohibited for Palestinian use and hence act as a barrier along the Wall and checkpoints, completely enclosing and surrounding these communities in separate clusters.

Eastern Wall Segment

The path of the Wall along the eastern side of the West Bank that would sever the entire Jordan Valley from the heart of the West Bank.

Enclave / Cluster

Enclave or cluster is an area in the West Bank encircled by the Wall and other barriers, such as gates, bypass roads or checkpoints.

First Phase

The path of the Wall whose construction started in June 2002 by the Israeli Government along a 157 km swatch in the West Bank districts of Jenin, Tulkarem and Qalqiliya as well as parts of Ramallah, Jerusalem and Bethlehem. Status: Complete.

Gate

Gates that allow restricted movement of Palestinians through the Wall or at the entrance to their villages. The gates have specific opening hours (usually arbitrary and insufficient) and are managed by Israeli soldiers. To cross a Wall gate, Palestinians require permits.

Green Line

The Green Line represents the borders that existed before the 1967 war and measures 350 kilometres.

Jerusalem Envelope

The path of the Wall around East Jerusalem including clusters 16, 17, 18, 19, 20, 21 and 28 (see Map 8 and Map 14).

PHC Level 1

- Preventive services: mother and child health care and immunization.
- Curative services: first aid.

PHC Level 2

- Preventive services: mother and child health care and immunization
- Curative services: General Practitioner (GP) medical care
- Laboratory (in some clinics)

PHC Level 3

- Preventive services: mother and child health care, immunization, family planning and dental.
- Curative services: General Practioner (GP) and medical specialist
- Laboratory
- Health education

PHC Level 4

- Preventive services: mother and child health care, immunization, family planning and dental.
- Curative services: General Practitioner (GP), medical specialist and dental care
- Gynaecology and obstetric
- Laboratory
- Radiology
- Health education
- Emergency Medical Services (EMS)

Second Phase

The path of the Wall whose construction began in March 2003 by the Israeli Government throughout the West Bank districts of Qalqiliya, Salfit, Ramallah, Jerusalem, Bethlehem and Hebron. Status: Partially constructed and currently under construction.

Outside the Wall

Palestinian lands and communities located inside the West Bank that are not enclosed completely by the Wall or other structures and are not located in between the Green Line and the Wall. These are areas near the Wall but from the other side and are not considered enclosed.

Annex 2: Acronyms

BASR	Bethlehem Arab Society for Rehabilitation.
CBR	Community Based Rehabilitation.
CRS	Catholic Relief Services.
DISVI	Disarmo e Sviluppo International Cooperation.
ECHO	European Commission Humanitarian Aid Office.
GAM	Global Acute Malnutrition.
GHI	Governmental Health Insurance.
GIS	Geographic Information System.
GoI	Government of Israel.
HCC	Health Care Committees.
HDIP	Health, Development, Information and Policy Institute.
HWC	Health Work Committees.
ICJ	International Court of Justice.
IHCJ	Israeli High Court of Justice.
ICRC	International Committee of the Red Cross.
IRC	International Red Cross.
MoH	Ministry of Health.
NGO	Non-Governmental Organization.
OCHA	United Nations Office for the Coordination of Humanitarian Affairs.
PCBS	Palestinian Central Bureau of Statistics.
PFS	Patients Friends Society.
PHC	Primary Health Care.
PHR	Physicians for Human Rights.
PMRS	Palestinian Medical Relief Society.
PNA	Palestinian National Authority.
PRCS	Palestinian Red Crescent Society.
PUD	Palestinian Union of Disabled.
UNRWA	The United Nations Relief Works Agency.
WHO	World Health Organization.

Annex 3: Population table and clusters

All enclave numbers that are not listed in these tables have no Palestinian communities but are considered as crucial agricultural lands.

Enclave 1
Jenin & Tulkarem district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Umm ar Rihan	No	53	12	2	8	0	24	2	5	3	318	47	7	2	21
Khirbet 'Abdallah al Younis	No	139	32	6	24	1	62	4	12	8	834	122	17	4	56
Barta'a ash Sharqiya	1 MoH clinic	3.552	810	162	648	24	1584	107	320	202	21312	3140	455	114	1435
Khirbet ash Sheikh Sa'eed	No	215	49	9	38	1	96	6	20	12	1290	190	27	7	87
Khirbet al Muntar al Gharbiya	No	29	6	1	5	0	12	1	3	2	174	26	4	1	11
Khirbet al Muntar al Sharqiya	No	15	3	1	3	0	7	0	1	1	90	13	2	0	6
Dhaher al malih	No	215	49	9	38	1	96	6	20	12	1290	190	27	7	87
Total	**1 MoH clinic**	**4218**	**961**	**190**	**764**	**27**	**1881**	**126**	**381**	**240**	**25308**	**3728**	**539**	**135**	**1703**

Status of clinics isolated in enclave 1 – Jenin & Tulkarem district

Level 2

Infrastructure			Programmes and services									
Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
1	0	0	1	0	1	1	1	0	0	0	1	1

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
1	1	0	1	1	0

Enclave 4
Qalqiliya city

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Qalqilya city	2 MoH, 1 NGO, 1 Prv	43625	9947	1989	7958	298	19457	1309	3926	2487	261750	38565	5584	1396	17625
Total	**2 MoH, 1 NGO, 1 Prv**	**43625**	**9947**	**1989**	**7958**	**298**	**19457**	**1309**	**3926**	**2487**	**261750**	**38565**	**5584**	**1396**	**17625**

Status of clinics isolated in enclave 4 - Qalqiliya city

	Infrastructure			Programmes and services									
	Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
Level 3	4	4	3 simple 1 adv	2	1	2	2	1	3	3	2	4	1

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
4	4	3	3	3	3

Enclave 5
Qalqiliya district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Ad Dab'a	1 MOH clinic	[illegible]	60	12	48	2	117	8	24	15	1578	232	34	7	106
'Arab Abu Farda	No	89	20	4	16	1	40	3	8	5	534	79	11	3	35
Ras at Tira	No	486	88	17	67	3	172	11	33	21	2316	341	47	12	149
'Arab ar Ramadin al Janubi	No	196	43	8	33	1	85	5	16	10	1140	168	23	6	72
Total	**1 MOH clinic**	**1191**	**211**	**41**	**164**	**7**	**414**	**27**	**81**	**51**	**5568**	**820**	**115**	**28**	**362**

Status of clinics isolated in enclave 5 - Qalqiliya district

	Infrastructure			Programmes and services									
	Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
Level 2	1	0	0	1	0	1	1	1	0	0	0	0	0

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
0	0	1	0	0	0

Enclave 6
Qalqiliya district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Habla	1 MOH, 1 NGO	6001	1368	274	1096	41	2676	180	540	342	36006	5304	768	192	2400
Ras Atiya	1 MOH	1560	356	71	284	11	696	47	140	89	9360	1379	200	50	624
Total	**2 MOH, 1 NGO**	**7561**	**1724**	**345**	**1380**	**52**	**3372**	**227**	**680**	**431**	**45366**	**6683**	**968**	**2242**	**3024**

Status of clinics isolated in enclave 6 - Qalqiliya district

2 Level 2 & 1 Level 3

Infrastructure			Programmes and services								
Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
2	2	1	1	0	2	2	1	1	1	0	3	0

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
3	3	3	2	3	2

Enclave 9
'Azzun 'Atma

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
'Azzun 'Atma	1 MOH	257	59	12	48	2	115	8	23	15	1542	227	33	8	103
Total	**1 MOH**	**257**	**59**	**12**	**48**	**2**	**115**	**8**	**23**	**15**	**1542**	**227**	**33**	**8**	**103**

Status of clinics isolated in enclave 6 - Qalqiliya district

Level 2

Infrastructure			Programmes and services								
Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
1	0	0	1	0	0	1	1	0	0	0	1	1

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
1	1	0	0	0	0

Enclave 10
Salfit district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Mas-ha	No	1942	443	89	354	13	866	58	175	111	11652	1717	249	62	777
Az Zawiya	1 MOH clinic	2271	518	104	414	15	1013	68	204	129	13626	2008	291	73	917
Rafat	1 MOH clinic	1976	451	90	360	14	881	59	178	113	11856	3009	436	109	1375
Deir Ballut	1 MOH clinic	3610	823	165	658	25	1610	108	325	206	21660	3191	462	116	1458
Total	**1 MOH clinic**	**9799**	**2235**	**448**	**1786**	**67**	**4370**	**293**	**882**	**559**	**58794**	**9925**	**1438**	**360**	**4527**

Status of clinics isolated in enclave 10 - Salfit district

	Infrastructure			Programmes and services									
	Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
Level 2	2	0	0	3	0	1	3	0	2	0	0	3	1

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
3	3	0	3	2	3

Enclave 11
Qalqiliya, Salfit & Ramallah

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Dar Abu Basal	No	4	1	0	4	0	2	0	0	0	24	3	0	0	3
Khirbet Susa	No	11	3	1	11	3	6	0	0	0	66	10	1	0	4
'Izbet Abu Adam	No	40	9	2	8	1	18	1	3	2	160	35	5	1	16
Total	**NO CLINIC**	**55**	**13**	**3**	**22**	**1**	**26**	**1**	**3**	**2**	**250**	**48**	**6**	**1**	**23**

Enclave 15
Ramallah district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Beit Sira	1 MOH clinic	2768	631	126	505	19	1235	83	249	158	16608	2447	354	86	1118
Kharbatha al Misbah	1 MOH clinic	5112	1168	234	934	35	2280	153	460	291	30672	4519	654	164	2065
At Tira	1 MOH clinic	1601	365	73	292	11	714	48	144	91	9606	1415	205	51	647
Beit Liqya	1 MOH clinic	7863	1793	359	1434	54	3507	236	708	448	47178	6951	1006	252	3177
Beit Nuba	No clinic	285	65	13	52	2	127	9	26	16	1710	252	36	9	115
Beit Duqqu	1 NGO clinic	1575	359	72	287	11	702	47	141	90	9450	1392	202	50	636
Beit 'Anan	1 NGO clinic	4196	957	191	765	29	1871	126	378	239	25176	3709	537	134	1695
Beit Ijza	No clinic	660	150	30	120	5	294	20	60	38	3960	583	84	21	267
Biddu	2 NGO clinic	6267	1429	286	1143	43	2795	188	564	357	37602	5540	802	200	2532
Qatanna	2 NGO clinic	7377	1682	336	1346	50	3290	221	664	420	4262	6521	944	236	2980
Al Qubibeh	1 MOH clinic	2035	464	93	371	14	908	61	183	116	12210	1799	260	65	822
Beit Surik	No clinic	3756	856	171	685	26	1675	113	338	214	22536	3320	481	120	1517
Total	**5 MOH, 6 NGO**	**43495**	**9919**	**1984**	**7934**	**299**	**19398**	**1305**	**3915**	**2478**	**220970**	**38448**	**5565**	**1388**	**17571**

Status of clinics isolated in enclave 15 - Ramallah district

2 Level 2, 3 Level 2, 6 Level 3

Infrastructure			Programmes and services								
Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
11	9	6	6	3	8	9	9	7	5	3	8	5

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
9	8	6	9	6	7

Enclave 17 Jerusalem district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Beit Iksa	1 MOH clinic	1545	332	66	287	11	702	47	141	90	9450	1392	202	50	636
An nabi Samwil	No clinic	215	49	9	38	1	96	6	20	12	1290	190	27	7	87
Total	**1 MOH clinic**	**1760**	**381**	**75**	**325**	**12**	**798**	**53**	**161**	**102**	**10740**	**1582**	**229**	**57**	**723**

Status of clinics isolated in enclave 17 - Jerusalem district

Level 2

Infrastructure			Programmes and services									
Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
1	1	0	1	0	0	1	1	0	1	0	1	0

Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
1	0	0	0	1	0

Enclave 18 Ramallah & Jerusalem district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Al Judeira	No	2088	476	95	380	14	931	61	183	116	12528	1846	260	65	822
Al Jib	No	4567	957	191	765	29	1871	126	378	239	27402	3709	537	134	1695
Bir Nabala	1 NGO clinic	5993	1368	274	1096	41	2676	180	540	342	35958	5304	768	192	2400
Beit Hanina al Balad	1 MOH clinic	1364	311	62	249	9	608	41	123	78	8184	1206	175	44	551
Total	**1 MOH clinic**	**14012**	**3112**	**622**	**2490**	**93**	**6086**	**408**	**1224**	**775**	**84072**	**12065**	**1740**	**435**	**5468**

Status of clinics isolated in enclave 18 - Ramallah & Jerusalem district

	Infrastructure			Programmes and services									
Level 2 & Level 3	Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
	2	1	1	2	0	1	2	1	1	2	0	2	0

Availability of equipment				
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
	1	1	1	2	1

Enclave 21
Az Za'ayyem

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Az Za'ayyem	No	2420	548	109	438	16	1079	73	218	138	14520	2139	310	73	978
Total	**No clinic**	**2420**	**548**	**109**	**438**	**16**	**1079**	**73**	**218**	**138**	**14520**	**2139**	**310**	**73**	**978**

Enclave 22
Al Walaja

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Al Walaja	No	1665	380	76	304	11	743	48	144	91	9990	1472	213	51	673
Total	**No clinic**	**1665**	**380**	**76**	**304**	**11**	**743**	**48**	**144**	**91**	**9990**	**1472**	**213**	**51**	**673**

Enclave 24
Bethlehem & Hebron district

Locality	Health service	2004 Population	% of women at child bearing age (A)	% of preg from A (B)	preg visits/minimum 4	% of high risk preg from B	% children under 15 years	% disabilities	% diabetes	% chronic diseases	PHC visits: 6visit/person	% Person visits medical care (non prvt)	% person visit dental clinic	% person visit optical clinic (non prvt)	% person visit hospitals
			22.8%	20%		15%	44.6%	3%	9%	5.7%		88.4%	12.8%	3.2%	40.4%
Battir	1 MOH clinic	4147	956	191	765	29	1871	126	378	239	25176	3709	537	134	1695
Husan	1 MOH clinic	5609	1279	256	1023	38	2502	168	505	320	33654	4958	18	179	2266
Nahhalin	2 MOH, 2 NGO	6298	1429	286	1143	43	2795	188	564	357	37602	5540	802	200	2535
Khallet 'Afana	No clinic	4	1	0	4	0	2	0	0	0	24	3	0	0	3
Wadi Fukin	1 MOH clinic	1180	269	54	215	8	526	35	106	67	7080	1043	151	38	477
Khallet Sakariya	No clinic	83	20	4	16	1	40	3	8	5	534	79	11	3	35
Khallet al Balluta	No clinic	167	40	8	32	2	80	6	15	10	1002	158	22	6	70
Total	**4 MOH, 2 NGO**	**17488**	**3994**	**799**	**3198**	**121**	**7816**	**526**	**1576**	**998**	**105072**	**15490**	**1541**	**560**	**7078**

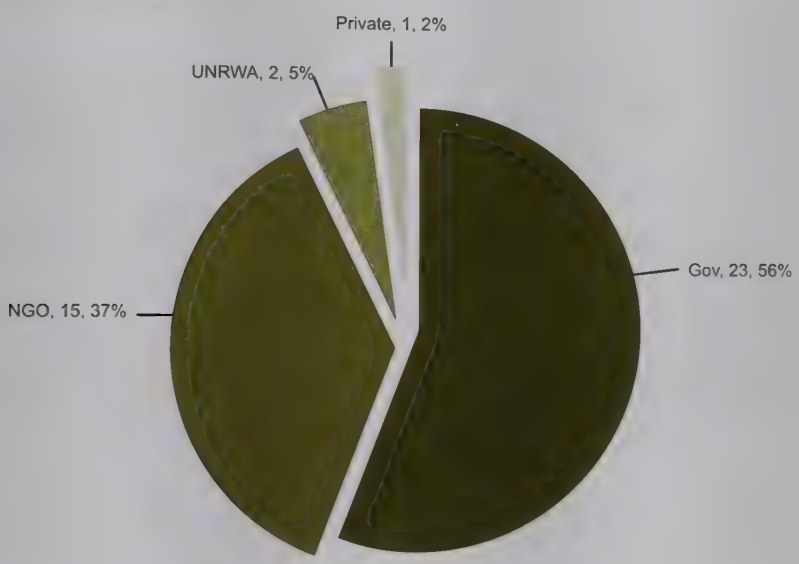
Status of clinics isolated in enclave 24 - Bethlehem district

	Infrastructure			Programmes and services								
	Electricity	Pharm	Lab	Vacc	Delivery	Prenatl	Postnatl	Wibby	F.P	Screen	Diabetes	Health education	Staff education
2 Level 1, 2 Level 2 & Level 3	6	6	2	4	1	1	3	5	4	1	0	4	1

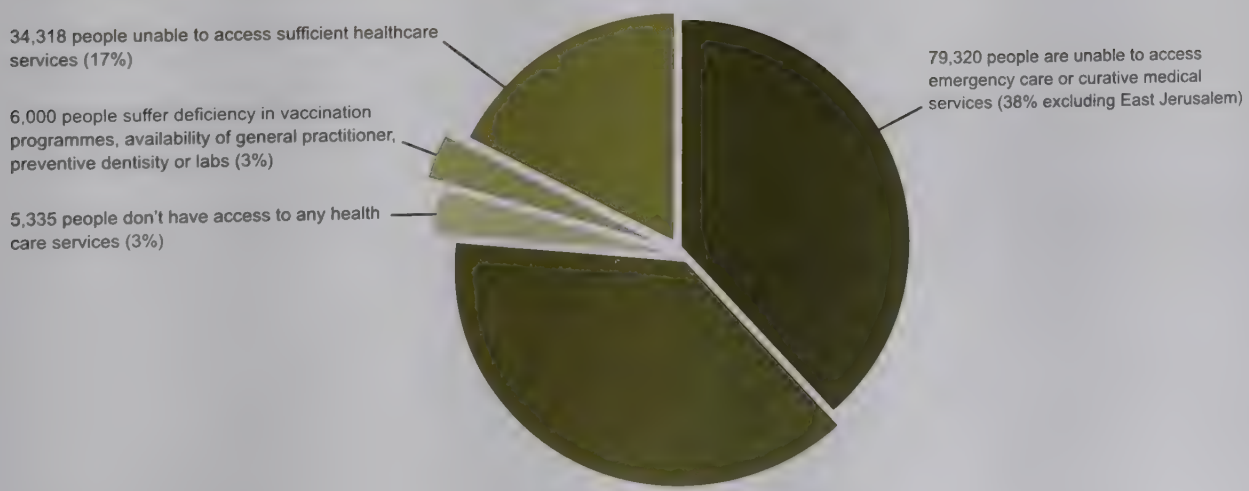
Availability of equipment					
Otoscope	Ophthalmoscope	Stretcher	Oxygen bottle	Sonic Aid	I.V. Lines
6	4	2	5	3	4

Annex 4: Capacities of clinics

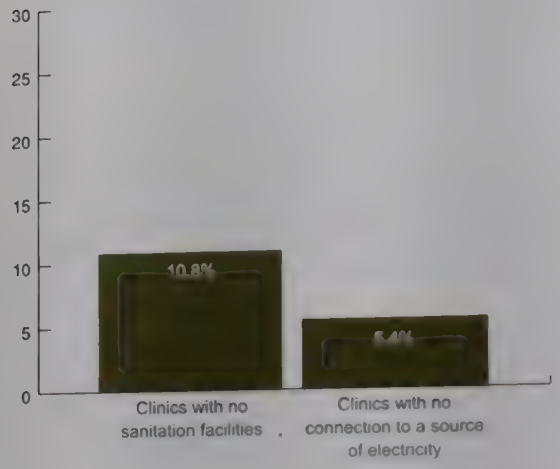
Number of isolated clinics by provider



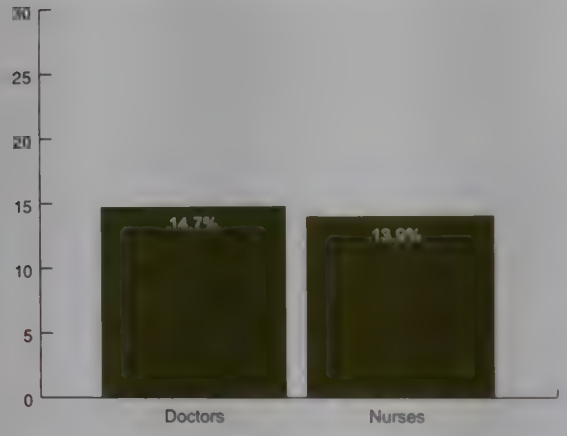
The healthcare effect on the enclaved population



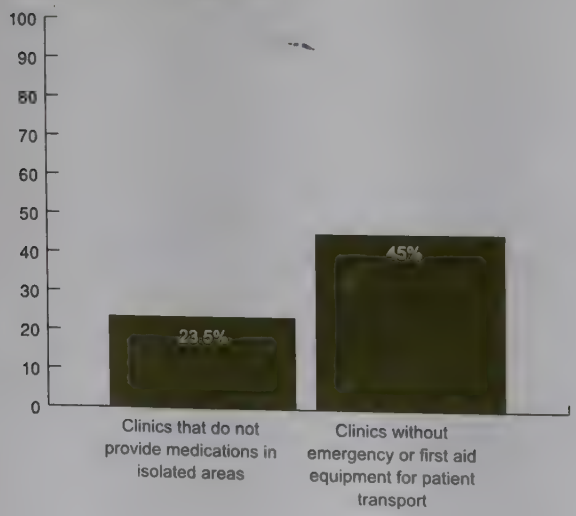
Logistic Capacity



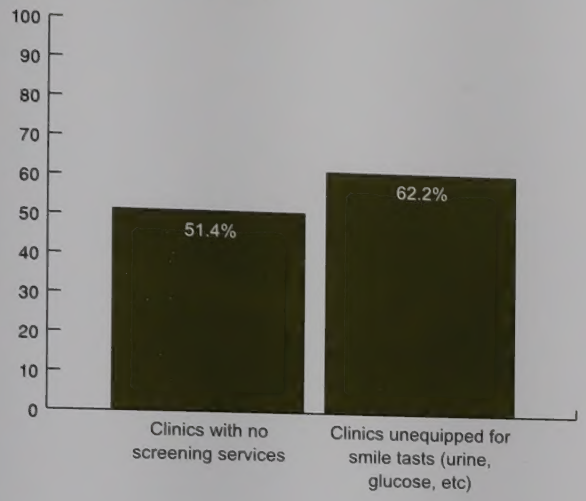
Human Resources: Percentage of doctors and nurses who have to travel through checkpoints



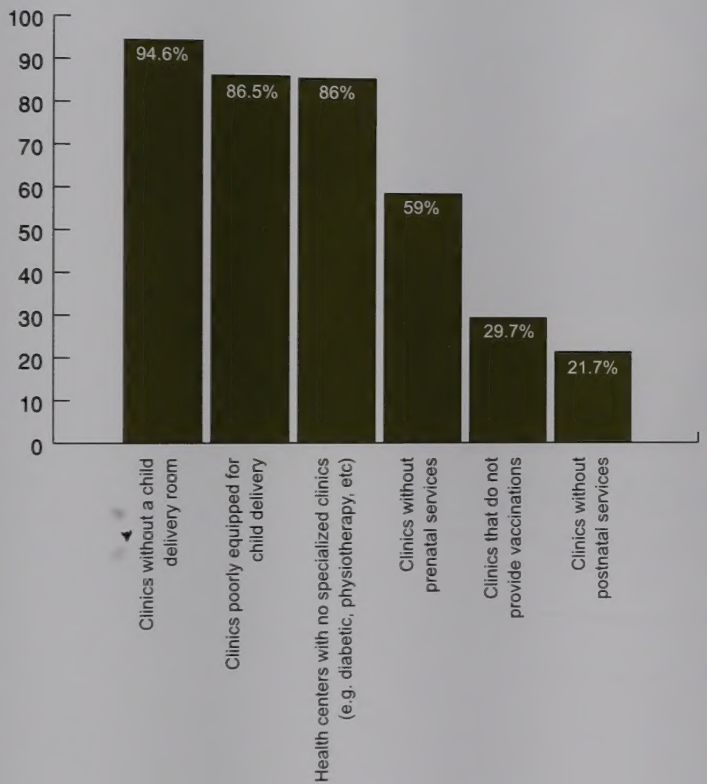
Supplies & Equipment



Diagnostic Capacity



Services



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